Supreme Court, U.S.
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No. 00-

IN THE

Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Section 4-10 of the Illinois Health Maintenance Organization Act provides that, if a patient's primary care physician deems a proposed procedure desired by the patient to be medically necessary, but the HMO disagrees and denies coverage for the procedure, the patient may have the HMO's decision reviewed by an outside physician, and the HMO must abide by the reviewing physician's determination. The Seventh Circuit held in this case that this independent review process was not preempted by the Employee Retirement Income Security Act ("ERISA")—in square conflict with a recent Fifth Circuit decision holding that a materially identical Texas law *was* preempted by ERISA.

The question presented is:

Whether the independent review provision of the Illinois HMO Act, which is similar to laws adopted in 37 states and the District of Columbia, is preempted by ERISA.

RULE 29.6 STATEMENT

Petitioner Rush Prudential HMO, Inc., now known as UNICARE Health Plans of the Midwest, Inc., is wholly owned by UNICARE Health Plans, an Illinois general partnership, which is ultimately owned by Wellpoint Health Networks, Inc., a publicly held company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Rush Prudential HMO, Inc., respectfully petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the Seventh Circuit, together with the dissent from denial of rehearing en banc, is reported at 230 F.3d 959. The opinion is reproduced in the appendix hereto ("App.") at 1a, and the dissent from denial of rehearing en banc is reproduced at App. 24a. The opinions and orders of the United States District Court for the Northern District of Illinois dated June 9, 1998, March 24, 1999, May 6, 1999, and June 15, 1999, are not reported; they are reproduced at App. 28a, 35a, 44a, and 47a, respectively.

JURISDICTION

The judgment of the Seventh Circuit was entered on October 19, 2000. App. 1a. The jurisdiction of the Seventh Circuit was based on 28 U.S.C. § 1291. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides in pertinent part:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof * * * shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding. [U.S. Const., art. VI, cl. 2.]

Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA")—the statute's civil enforcement provision—provides in pertinent part:

> (a) Persons empowered to bring a civil action. A civil action may be brought—(1) by a participant or beneficiary—(A) for the relief provided for in subsection (c) of this section, or (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan * * *. [29 U.S.C. § 1132(a).]

Section 514(a) of ERISA—the preemption provision—provides in pertinent part:

> (a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in

> section 1003(a) of this title and not exempt under section 1003(b) of this title. [29 U.S.C. § 1144(a).]

Section 514(b)(2)(A) of ERISA—the savings clause—provides:

> (b) Construction and application. * * * (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. [29 U.S.C. § 1144(b)(2)(A).]

Section 4-10 of the Illinois Health Maintenance Organization Act provides:

> Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure. [215 Ill. Comp. Stat. 125/4-10.]

INTRODUCTION

Health Maintenance Organizations, or HMOs, have become a prominent feature of the American health care system. "The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed." *Pegram* v. *Herdrich*, 120 S. Ct. 2143, 2149 (2000). HMOs "commonly require utilization review (in which specific treatment decisions are reviewed by a decisionmaker other than the treating physician) and approval in advance (precertification) for many types of care, keyed to standards of medical necessity or the reasonableness of the proposed treatment." *Id.* The rise of the HMO has drawn the attention of state lawmakers, who have increasingly subjected these organizations to additional regulation.

Petitioner Rush Prudential HMO, Inc. ("Rush") is an HMO that provided access to medical and hospital care for a medical benefits plan sponsored by the employer of the husband of respondent Debra C. Moran ("Moran"). The plan is an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* Under the applicable Certificate of Group Coverage ("Certificate"), Rush provides coverage only when it determines services to be "medically necessary," and it exercises "the broadest possible discretion" to make that determination.

At issue in this case is whether ERISA preempts an Illinois statute providing for the binding independent review of an HMO's decision regarding the medical necessity of a proposed procedure. At last count, thirty-seven States and the District of Columbia had enacted such "independent review" or "external appeal" statutes.

The Seventh Circuit held in this case that ERISA does not preempt the Illinois law, and in so doing prompted Judge Posner, joined by three other judges, to dissent from the

denial of rehearing en banc. Judge Posner noted that "[t]his case is well worth the attention of the full court. The panel's decision creates a square conflict with another circuit, is very probably unsound, and will affect an enormous number of cases." App. 24a. He added that "[i]t is also a single issue case, and the issue is one of law, so that en banc consideration would be unlikely to create a fractured result or bog the court down in factual questions. Rarely have we had so strong a candidate for en banc review." *Id.*

The same compelling reasons that made this case a strong candidate for en banc review also make it a front-runner for review by this Court. The decision below directly conflicts with a recent decision of the Fifth Circuit—a fact that the panel below as well as Judge Posner expressly recognized. *See Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor* v. *Corporate Health Ins., Inc.*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665).[1] And because over two-thirds of the States have adopted independent review statutes relevantly similar to the Illinois law at issue here and the Texas law at issue in *Corporate Health*, the ERISA preemption questions raised by such statutes are guaranteed to arise again and again. This Court should review the Seventh Circuit's "startling decision," App. 26a (Posner, J.), and resolve the conflict among the circuits on this weighty issue.

STATEMENT OF THE CASE

Facts. Moran sought treatment in 1996 from Dr. Arthur LaMarre, a Rush-affiliated primary care physician, for pain, numbness, loss of function, and decreased mobility in her right shoulder. App. 3a. LaMarre attempted to relieve Moran's symptoms through physiotherapy. *Id.* at 3a-4a.

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[1] This petition has been served on all the parties in *Corporate Health*.

While she was still undergoing this treatment, Moran sought the opinion of Dr. Julia Terzis, an out-of-network surgeon in Virginia. Terzis confirmed the diagnosis of Moran's symptoms as "brachial plexopathy and thoracic outlet syndrome ('TOS'), a nerve compression syndrome caused by the compression of nerves in Ms. Moran's brachial plexis." *Id.* at 4a.

As treatment for Moran's condition, "surgery is not indicated unless more conservative measures"—such as the physiotherapy that LaMarre had already prescribed—"fail to manage the symptoms." *Id.* In the event that surgery is necessary, "the standard procedure for TOS involves decompression by way of first rib resection (the complete removal of the uppermost rib) or first rib resection with scalenectomy (the removal of the rib and the attached muscle)." *Id.* Terzis, however, recommended for Moran a more complicated and rare form of TOS surgery that Terzis herself had developed: "Dr. Terzis' surgery consists of rib resection, extensive scalenectomy, and, if indicated, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification." *Id.*

Moran asked LaMarre to obtain approval from Rush for this complicated surgery suggested by Terzis. LaMarre sought out the views of two other surgeons, neither of whom recommended the Terzis surgery for Moran. *Id.* at 5a. After Rush declined to approve payment for the treatment because it was not medically necessary, Moran appealed the decision pursuant to the review procedure provided under the benefit plan. Upon further review, Rush affirmed its denial on the ground that the extensive surgery proposed by Terzis was not medically necessary, but advised Moran that it would cover the standard TOS surgery—first rib resection with scalenectomy—performed by a network surgeon. *Id.* An additional appeal to Rush's membership advisory committee upheld Rush's medical necessity decision. *Id.*

Having exhausted the various review procedures provided in the benefit plan without obtaining a favorable ruling on medical necessity, Moran next sought to invoke the additional external review procedure established by Section 4-10 of the Illinois HMO Act, under which a determination by the HMO that a procedure is not medically necessary is reviewed by an independent physician. *See supra* at 3. While Moran's request for independent review was still pending, Moran decided to undergo the microneurolysis surgery. Dr. Terzis performed the 14-hour procedure, which together with post-operative care cost nearly $95,000. After paying for the surgery herself, Moran sought reimbursement from Rush. Rush undertook yet another investigation of the claim, seeking opinions from additional experts. None of the doctors consulted by Rush concluded that Moran's surgery was medically necessary, and Rush declined to reimburse Moran. *Id.* at 6a.

Proceedings Below. This litigation began when Moran filed a complaint in state court seeking, *inter alia*, specific performance of the external review provisions in Section 4-10 of the Illinois law.[2] The state court ordered Rush to permit the review provided for in Section 4-10. That review was conducted by one Dr. Dellon, who "concluded that the surgery was medically necessary," App. 8a, while noting that

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[2] Because the complaint sought to obtain or compel benefits under an ERISA-regulated employee welfare benefit plan and was, in Rush's view, completely preempted by federal law, Rush removed the case to federal court. Moran moved to remand to state court, and the district court granted her motion. The court reasoned that the request for specific performance of the review procedure was not a claim under ERISA's civil enforcement provisions and therefore was not completely preempted. The district court also noted that a claim for reimbursement after the external review had been completed might well be a claim for benefits that is completely preempted by ERISA. *See* App. 33a-34a.

he would have used a less intrusive and less time-consuming procedure. *Id.* After reviewing Dr. Dellon's report and reports from three other physicians, Rush again denied Moran's claim on the ground that the surgery was not medically necessary.

Moran amended her complaint to seek reimbursement for the surgery in the amount of $94,841.27. Rush removed the suit to federal court on the ground that a demand for reimbursement is completely preempted by ERISA and must be brought under Section 502(a) of ERISA, the statute's civil enforcement provision. 29 U.S.C. § 1132(a). Recognizing that the claim was now simply one for benefits, the district court denied Moran's motion to remand.

The district court then determined that Moran's Section 4-10 demand for payment was "preempted by ERISA's civil enforcement policy in § 502(a)." App. 53a. As the court explained: "Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan. Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. Accordingly, Moran's claim for reimbursement is preempted by ERISA." App. 41a-42a.

The district court also rejected Moran's effort to escape preemption through the so-called "savings clause," 29 U.S.C. § 1144(b)(2)(A) ("nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance"). Finding that the state law "does not operate to transfer or spread a policyholder's risk" but only "affects * * * particular instances," the district court concluded that Section 4-10 is not a law that "regulates insurance" and that the savings clause therefore did not

rescue the state law from preemption. App. 42a-43a.[3] Analyzing Moran's demand for reimbursement under principles of federal law, the district court entered summary judgment for Rush on the ground that "Rush did not abuse its discretion or act arbitrarily in denying Moran's benefit claim." App. 56a.

The Seventh Circuit reversed. It first determined that removal was proper because "Ms. Moran's state law claims are properly recharacterized as claims for benefits under Section 502(a)(1)(B) of ERISA and, therefore, are completely preempted." App. 13a. The court of appeals also concluded that the state law claims were initially within the reach of ERISA's express preemption provision, found in Section 514(a) of the Act. 29 U.S.C. § 1144(a) (except as provided in subparagraph (b), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter related to any employee benefit plan"). *See* App. 14a.

The Seventh Circuit then considered whether Section 4-10 regulates insurance and therefore could escape preemption under the savings clause of Section 514(b)(2)(A). The court noted (App. 16a) that, after *Ward*, the determination whether a law regulates insurance first requires examination of "whether, from 'a common-sense view of the matter,' the contested prescription regulates insurance." *Ward*, 526 U.S. at 367 (quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 740 (1985)). The court next is directed to

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[3] The district court's initial decision on the savings clause came before this Court's decision in *UNUM Life Insurance Co.* v. *Ward*, 526 U.S. 358 (1999), which clarified the test to be applied for determining when a law "regulates insurance." After *Ward*, Moran sought reconsideration. The district court determined that even if the savings clause applied, an exemption from the clause—the so-called "deemer clause"—once again gave preemptive effect to the federal law. App. 46a (citing 29 U.S.C. § 1144(b)(2)(B)).

consider "three factors employed to determine whether the regulation fits within the 'business of insurance' as that term is used in the McCarran-Ferguson Act." *Ward*, 526 U.S. at 367. These factors are whether the practice (1) has the effect of transferring or spreading a policyholder's risk, (2) is an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry. *See* App. 16a-17a.

The Seventh Circuit concluded "that § 4-10 of the HMO Act falls within the saving clause because it 'regulates insurance' under a common sense understanding and because it meets at least two of the McCarran-Ferguson factors"—the second and third factors identified above. App. 17a. The court also determined that the "deemer clause"—under which the preemptive effect of federal law is restored despite the fact that a state law regulates insurance—did not apply in this case. *Id.* at 18a-19a. The employee welfare benefit plan here is not self-funded but rather is an insured plan, and the court of appeals determined that the deemer clause did not apply to such plans. *Id.* at 18a.

The Seventh Circuit then considered whether Section 4-10, despite falling within the savings clause, was nonetheless preempted because it "conflicts with a substantive provision of ERISA." *Id* at 19a. Despite having concluded when considering the propriety of removal that "Ms. Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA and, therefore, are completely preempted," App. 13a, the court now found that the provisions of Section 4-10 were *not* preempted by Section 502(a)(1)(B). App. 19a-23a. It reasoned that the provisions of Section 4-10 were incorporated into the plan and that therefore "a suit by [Moran] to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) 'to enforce rights' and 'to recover benefits' under the plan." App. 21a.

The court recognized that its decision conflicted with the Fifth Circuit's decision in *Corporate Health*, "in which the court considered an independent review statute from Texas that is quite similar to § 4-10 of Illinois' HMO Act." App. 19a. The Seventh Circuit disagreed with the Fifth Circuit's conclusion that the state law independent review mechanism created an alternative civil enforcement scheme in addition to and inconsistent with that provided in ERISA itself. It relied instead on its view that Section 4-10 creates an additional term of the plan by operation of law. Thus, it concluded that a suit to enforce rights under the provision "is simply a suit to enforce the terms of the plan," and not an enforcement mechanism in addition to the exclusive mechanism provided by ERISA. *Id.* at 21a. Applying Section 4-10, the court of appeals reversed the district court's summary judgment in favor of Rush and granted summary judgment to Moran. *Id.* at 24a.

In light of the conflict between the panel's decision and the Fifth Circuit's decision in *Corporate Health*, Seventh Circuit rules required the panel to circulate the opinion to the entire court prior to publication. *See* App. 23a n.7 (citing Circuit Rule 40(e) ("A proposed opinion approved by a panel of this court adopting a position which would * * * create a conflict between or among circuits shall not be published unless it is first circulated among the active members of this court and a majority of them do not vote to rehear en banc the issue of whether the new position should be adopted.")). Four circuit judges voted to rehear the case en banc. Writing for those judges in a dissent from the denial of rehearing en banc, Judge Posner observed that the case "is well worth the attention of the full court." App. 24a. He explained:

> The panel's decision creates a square conflict with another circuit, is probably unsound, and will affect an enormous number of cases. It is also a single-issue case, and the issue is one of law, so that en banc consideration would be unlikely to create a fractured result or bog the

court down in factual questions. Rarely have we had so strong a candidate for en banc review. [*Id.*]

In the view of the dissenters, "[t]he Illinois statute, unless preempted by ERISA insofar as the statute's application to ERISA plans is concerned, will * * * effect a substantial change in the employer's plan." *Id.* at 25a. The state law "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans," and therefore "interferes with the federally specified system for enforcing such entitlements." *Id.* at 25a-26a. The dissenters found the panel's decision "startling," and observed that the panel's reliance on the fiction that state law is incorporated into the plan would permit "transparent * * * evasion[s] of ERISA's preemption clause." *Id.* at 26a-27a.[4]

Finally, the dissenters noted the "unresolved tension in the panel's opinion" between two propositions on which it relied: "first, that the Illinois law regulates insurance rather than ERISA plans and thus is not preempted; second, that by virtue of Illinois law the requirement of independent physician review is written not only into an insurance contract but also into the plan itself, which makes the requirement enforceable in federal court." *Id.* at 27a. Judge Posner explained that "[t]he two propositions are incompatible." *Id.*

> If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan—which means that its law is preempted. [*Id.*]

[4] The dissenters also concluded that the decision is "in tension with *Pegram* v. *Herdrich*, 120 S. Ct. 2143 (2000)." App. 27a. They stated that "[a]lthough *Pegram* held that combined treatment-eligibility decisions by an HMO are not fiduciary decisions under ERISA, it did not doubt that ERISA applied to HMO-managed ERISA plans; the panel, by contrast, seems to think ERISA inapplicable to such plans." *Id.*

REASONS FOR GRANTING THE WRIT

I. THE SEVENTH CIRCUIT'S DECISION IN THIS CASE DIRECTLY CONFLICTS WITH THE FIFTH CIRCUIT'S DECISION IN *CORPORATE HEALTH*.

As Judge Posner observed in his dissenting opinion, the panel's decision in this case "creates a square conflict" (App. 24a) with the Fifth Circuit's decision in *Corporate Health Insurance, Inc.* v. *Texas Department of Insurance*, 215 F.3d 526 (5th Cir.), *further opinion on pet. for reh'g*, 220 F.3d 641 (5th Cir. 2000), *pet. for cert. filed sub nom., Montemayor* v. *Texas Dep't of Ins.*, 69 U.S.L.W. 3317 (Oct. 24, 2000) (No. 00-665). That fact is reason enough to grant the writ here. *See* S. Ct. R. 10(a); *Braxton* v. *United States*, 500 U.S. 344, 347 (1991) (a "principal purpose for which we use our certiorari jurisdiction * * * is to resolve conflicts among the United States courts of appeals").

In *Corporate Health*, the Fifth Circuit considered a Texas independent review statute that the Seventh Circuit recognized was "quite similar" (App. 19a) to Section 4-10 of the Illinois HMO Act. *See* App. 25a (Posner, J.) (the Texas and Illinois statutes are "materially identical").[5] Like Section 4-10, the Texas statute provides for "the independent review of

[5] *Cf. District of Columbia* v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992) (certiorari granted where District of Columbia statute was held preempted by ERISA but a "substantially similar" Connecticut statute had been held not preempted); *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 654 (1995) (certiorari granted where New York statute was preempted by ERISA but "similar" New Jersey statute was not).

health care determinations to decide whether they were appropriate and medically necessary" by "allow[ing] a patient who has been denied coverage to appeal to an outside organization." *Corporate Health*, 215 F.3d at 531,. 537. Thus, both laws "require[] HMOs to provide a mechanism for patients to obtain independent review of the need for a course of treatment." App. 19a. Unlike the Seventh Circuit, however, the Fifth Circuit was firmly of the view that "[s]uch an attempt to impose a state administrative regime governing coverage determinations is squarely within the ambit of ERISA's preemptive reach." *Corporate Health*, 215 F.3d at 537.

The Fifth Circuit first found that the independent review statute regulated insurance under ERISA's savings clause based on the application of the "common sense test" and the three McCarran-Ferguson factors. *See id.* at 537-538. The Fifth Circuit recognized that "[o]ur analysis does not end here, however, because even if the provisions would otherwise be saved, they may nonetheless be preempted if they conflict with a substantive provision of ERISA." *Id.* at 538. The Fifth Circuit observed that in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), this Court had held that "the exclusivity of ERISA's enforcement scheme * * * preempts not only directly conflicting remedial schemes, but also supplemental state law remedies. Thus, the saving clause does not operate if the state law at issue creates an alternative remedy for obtaining benefits under an ERISA plan." *Corporate Health*, 215 F.3d at 538-539 (footnote omitted).[6]

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[6] This Court held in *Pilot Life*, 481 U.S. at 54, as follows:

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Applying the *Pilot Life* analysis, the Fifth Circuit held that the independent review provisions of the Texas statute were preempted by Section 502(a) of ERISA, 29 U.S.C. § 1132(a). As Judge Higginbotham explained for the court:

> Here, the independent review provisions * * * establish a quasi-administrative procedure for the review of [benefits] denial and bind the ERISA plan to the decision of the independent review organization. This scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under § 1132(a)(1)(B) of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the saving clause. [*Id.* at 539.]

The State of Texas then sought panel rehearing, relying on the very same argument accepted by the Seventh Circuit in this case. Specifically, Texas "insist[ed] that the [independent review] provisions do not create an alternative mechanism for seeking benefits" but "merely implement[] a procedural right to obtain medical care by imposing a mandatory insurance contract term that goes to the heart of the insured-insurer relationship." 220 F.3d at 644 (quotation marks and ellipses omitted). The panel, however, roundly rejected this "ambitious spin" and denied the petition. *Id.* The Fifth Circuit reaffirmed that "the law is clear that Texas cannot provide a supplementary claims process by binding the HMO to pay for a treatment that is simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions." *Id.* at 645. The independent review provisions, said the court, "are plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance." *Id.*

Texas' petition for rehearing en banc was also denied, with the Fifth Circuit noting that "no member of this panel nor judge in regular active service on the court ha[d] requested that the court be polled on Rehearing En Banc." *Id.*

In sum, there is a direct conflict between the decisions of the Fifth and Seventh Circuits, a fact recognized not only by Judge Posner, but also by the panel itself. *See* App. 19a-21a, 22a n.7. Indeed, because of the Seventh Circuit panel's "respectful disagreement" with the Fifth Circuit (App. 22a n.7), the panel circulated its opinion prior to publication to all active judges on the Seventh Circuit pursuant to a local rule requiring such action whenever a panel proposes an opinion "creat[ing] a conflict between or among circuits." Seventh Cir. R. 40(e). Thus, the inter-circuit conflict has been expressly acknowledged by the court below. *Cf. Travelers*, 514 U.S. at 654 (certiorari granted where Second Circuit had recognized conflict with Third Circuit on ERISA preemption issue).

II. THIS COURT'S RESOLUTION OF THE CONFLICT AMONG THE CIRCUITS IS VITAL, AND THIS CASE IS AN IDEAL VEHICLE FOR RESOLVING THAT CONFLICT.

The matter over which the Fifth and Seventh Circuits are in conflict is an important one. *See* S. Ct. R. 10(a).[7] In recent years, state laws entitling a patient to an independent review or external appeal of an HMO's coverage decisions have

[7] The fact that four Seventh Circuit judges voted to rehear the case en banc also underscores the significance of the issue. *Cf. Boggs* v. *Boggs*, 520 U.S. 833, 838 (1997) (ERISA preemption case in which "[s]ix members of the Court of Appeals dissented from the failure to grant rehearing en banc."). The Secretary of Labor's filing of amicus briefs in the court below and in the Texas case also signals the importance of this case. *See* App. 2a n.1; *Corporate Health*, 215 F.3d at 532 n.5.

proliferated.[8] In 1998, eighteen states had enacted such laws. *See* K. Pollitz, G. Dallek & N. Tapay, Georgetown Univ. Inst. for Health Care Research & Policy, External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare 2-3 & Fig. 1 (Nov. 1998). In 1999, respondent Moran observed that "Illinois is one of at least 25 states now with independent review statutes." Moran 7th Cir. Br. 30. And by 2000, thirty-seven states and the District of Columbia had independent review laws. *See* Pet. for Cert. in *Corporate Health*, No. 00-665, at 29, 27 n.24 (citing statutes).[9] Thus, the question whether ERISA preempts such laws is a recurring one of unquestionable importance. *Cf. Boggs* v. *Boggs*, 520 U.S. at 836 (ERISA preemption issue was "of undoubted importance").[10]

[8] *See, e.g.*, Ariz. Rev. Stat. § 20-2537; Cal. Health & Safety Code § 1374.30; Cal. Ins. Code § 10169; Colo. Rev. Stat. § 10-16-113.5; Conn. Gen. Stat. § 38a-226c-d; D.C. Code § 32-571.7; Fla. Stat. §§ 641.511, 408.7056; Iowa Code §§ 514J.1-514J.14; Kan. Stat. § 40-22a13-a16; La. Rev. Stat. § 22:3081; Md. Ins. Code § 15-10A-05; Mich. Comp. Laws §§ 555.1901-.1929; Minn. Stat. § 62Q.73; Mo. Stat. § 376.1387; Mont. Code § 33-37-102; N.J. Stat. § 26:2S-11; N.Y. Pub. Health L. § 4910; Ohio Rev. Code § 1751.84; Okla. Stat. tit. 63, § 2528.6; Pa. Cons. Stat. tit. 40, § 991.2162; R.I. Gen. Laws § 23-17.12-10; Tenn. Code § 56-32-210; Texas Ins. Code §§ 20A.12A, 21.58A, 21.58C; Vt. Stat. tit. 8, § 4089f; Wash. Rev. Code § 48.43.535.

[9] Some states limit independent or external review to an HMO's determination that a proposed procedure is not medically necessary or appropriate, while others permit such review of a broader range of decisions. *See* G. Dallek & K. Pollitz, Georgetown Univ. Inst. for Health Care Research & Policy, External Review of Health Plan Decisions: An Update 6-7 (May 2000).

[10] Reflecting this Court's appreciation of the importance of resolving ERISA preemption questions is the large number of ERISA preemption cases decided by the Court. *See California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 334-335 (1997) (Scalia, J., concurring) (noting that

Judge Posner was also exactly on the mark when he stated that Section 4-10 of the Illinois HMO Act "will affect an enormous number of cases" and "effect a substantial change in the employer's plan." App. 24a-25a. In order for an HMO to offer customers health care coverage on an affordable basis, it must limit coverage to those procedures that genuinely are medically necessary and appropriate. For a variety of reasons, individuals may seek many services that are neither. *See Pegram* v. *Herdrich*, 120 S. Ct. at 2149. Section 4-10 of the Illinois HMO Act, like other laws granting a right to external review of medical necessity determinations, "adds heavy new procedural burdens to ERISA plans," and, as Judge Posner observed, "[t]hese burdens do not come without cost." App. 26a. Indeed, "[t]he expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize." *Id.* Thus, the perverse, but predictable, effect of laws granting independent review rights is actually to *reduce* available benefits and health care. As Judge Posner noted, "[p]iling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all." *Id.*

Furthermore, this Court has explained that the basic purpose of ERISA's preemption provision "was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657. The Court has also recognized that such a uniform national system "is difficult to achieve * * * if a benefit plan is subjected to differing regulatory require-

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between ERISA's enactment in 1974 and the 1996 Term the Court had granted certiorari in no fewer than 16 cases "to resolve conflicts in the Courts of Appeals regarding ERISA pre-emption of various sorts of state law"); *see also De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 808 n.1 (1997) ("The boundaries of ERISA's pre-emptive reach have been the focus of considerable attention from the Court.").

ments in differing States. A plan would be required * * * to process claims in a certain way in some States but not in others." *Fort Halifax Packing Co.* v. *Coyne*, 482 U.S. 1, 9 (1987). "A patchwork scheme of regulation," this Court has said, "would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Id.* at 11.

The Illinois HMO Act and other independent review statutes disrupt the uniformity intended by Congress. Indeed, as Judge Posner explained, every such law "undermines the statutory purpose of federal uniformity in the administration of ERISA plans. If such laws are permissible, the rights of participants in an ERISA plan will change as they are transferred by their employer from state to state, even though they are nominally under the same plan." App. 26a. The various state independent review statutes thus crea an "impediment to an employer's adoption of a uniform benefit administration scheme." *Fort Halifax*, 482 U.S. at 14.

Additionally, the reasoning by which the Seventh Circuit concluded that the independent review scheme established by the Illinois the HMO Act escaped preemption, if taken seriously, would make ERISA's preemption provision meaningless. The panel declared that Section 4-10 was not a mechanism for recovering plan benefits (for if it were it would conflict with ERISA's exclusive remedy) but "ought to be treated as mandated contract terms and treated as part of the insurance contract." App. 23a.

Judge Posner rightly pointed out, however, that such reasoning "invites states to evade the preemptive force of ERISA simply by deeming [their] regulations of ERISA plans to be plan terms." *Id.* at 27a. Such reasoning, for example, "would authorize a state to require ERISA plans to double their benefits"—"transparent[ly] an evasion of ERISA's preemption clause." *Id. See Fort Halifax*, 487 U.S.

at 16 (rejecting state supreme court's view that ERISA does not preempt state-mandated benefit plans because that approach "would permit States to circumvent ERISA's pre-emption provision, by allowing them to require directly what they are forbidden to regulate"); *see also Boggs* v. *Boggs*, 520 U.S. at 844 ("States are not free to change ERISA's structure and balance.").

Finally, this case is an excellent vehicle for resolving the question of ERISA's preemption of state independent review statutes. First, as Judge Posner noted, this is "a single-issue case" (App. 24a)—there is no issue in this case other than the ERISA preemption issue.[11] Second, this case comes to the Court on a well-developed record and in a concrete factual context, after discovery and summary judgment proceedings.[12] Third, representatives of all the interests affected by the Illinois statute are parties to this case—Rush, the HMO; Moran, the ERISA plan participant; and the State of Illinois, whose law is at issue.

III. THERE IS NO REASON FOR THIS COURT TO REFRAIN FROM RESOLVING THE CONFLICT AMONG THE CIRCUITS BECAUSE OF POSSIBLE FUTURE DEVELOPMENTS.

Given the square conflict among the circuits and the importance of the issue presented for review, there is no reason for this Court to let the issue percolate any longer. Indeed, in recent ERISA preemption cases, this Court has rightly declined to let demonstrated inter-circuit conflicts fester.

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[11] Unlike *Corporate Health*, the preemptive effect of the Federal Employee Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901 *et seq.*, is not an issue in this case. *See Corporate Health*, 215 F.3d at 539 (FEHBA preempts Texas independent review law).

[12] In *Corporate Health*, on the other hand, an HMO filed suit to enjoin the Texas statute and have it declared preempted by ERISA immediately after the law took effect. *See Corporate Health*, 215 F.3d at 531.

See, e.g., Dillingham, 519 U.S. at 323 (reviewing 2-1 circuit split); *Travelers*, 514 U.S. at 654 (reviewing 1-1 circuit split); *Greater Washington*, 506 U.S. at 129 (reviewing 1-1 circuit split); *FMC Corp.* v. *Holliday*, 498 U.S. 52, 56 (1990) (reviewing 2-1 circuit split).

The fact that certain bills introduced in the last Congress contained independent review proposals should not cause this Court to depart from its practice of resolving circuit conflicts. It is far from clear that a so-called Patients' Bill of Rights will become law in the foreseeable future or that if such a law were enacted it would include a right to an external appeal of medical necessity determinations applicable to ERISA plans. *See Into the Fire*, Modern Physician, Dec. 1, 2000, at 24 (noting that with an "almost evenly divided" Congress, "government gridlock is going to get worse, not better, making passage of major new healthcare legislation unlikely" and that "a patient bill of rights[] would be tough to implement" even in a political environment conducive to agreement); *Sen. Breaux to Revive Centrist Coalition, Urges Delaying Medicare Reform Debate*, Health Daily News, Dec. 6. 2000 (noting that Senator John Breaux of Louisiana has urged President-elect Bush to delay consideration of health care reform until 2002 and start with "something 'easier' " in his first year in office).

In November 2000, the Department of Labor issued new ERISA regulations to be codified at 29 C.F.R. § 2560.503-1 *et seq*. *See* 65 Fed. Reg. 70,246-65 (discussion of new regulations); *id.* at 70,265-71 (text of new regulations). The new regulations— which apply only to claims filed under a plan on or after January 1, 2002, *see* 29 C.F.R. § 2560.503-1(*o*) (reproduced at 65 Fed. Reg. 70,271)—will require all ERISA plans to provide the opportunity for a "full and fair" *internal* appeal of any adverse benefit determination to "an appropriate named fiduciary of the plan." 29 C.F.R. § 2560.503-1(h) (reproduced at 65 Fed. Reg. 70,268). The

new regulations do not, however, establish any right of *external* appeal.[13]

Furthermore, the new regulations expressly state that they are *not* to be construed as preempting any external appeal available under a state law regulating insurance. *See* 29 C.F.R. § 2560.503-1(k)(2)(i) ("a State law regulating insurance shall not be" preempted "merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity *other than* the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing") (reproduced at 65 Fed. Reg. 70,270-71) (emphasis added). Thus, the regulations do not preempt state external appeal laws. *See* 65 Fed. Reg. 70,255 ("Subparagraph (k)(2) articulates the Department's view that procedural remedies established by State law that are 'external' to the plan will not be preempted by the regulation."); *id.* at 70,254 (state "external review[]" laws are "beyond the scope of the regulation").

Accordingly, there is no reason for this Court to defer consideration of the questions presented to see what preemptive effect the lower courts give the new regulations vis-à-vis state external appeal statutes.

In issuing its new regulations, the Department of Labor acknowledged the "existing confusion about the possible pre-

[13] With respect to group health plans specifically, the new regulations state that an initial adverse benefit determination must be reviewed by a plan fiduciary who is not the same individual who made the initial determination nor that individual's subordinate, *see* 29 C.F.R. § 2560.503-1(h)(3)(ii), and that in an appeal of an adverse benefit determination based on a judgment that a particular treatment is not medically necessary or appropriate, the reviewing plan fiduciary shall consult with an appropriate health care professional, *see id.* § 2560.503-1(h)(3)(iii). 65 Fed. Reg. 70,269.

emption of State law efforts * * * providing State-mandated systems for the review of disputes between patients and health care providers or insurers." 65 Fed. Reg. 70,254. The Department did not resolve that confusion with its new regulations, nor could it have. This Court can and should.

IV. THE INDEPENDENT REVIEW PROVISION OF THE ILLINOIS HMO ACT IS PREEMPTED BY ERISA.

On the merits of the questions presented, Judge Posner's assessment was again correct: the Seventh Circuit's determination that ERISA does not preempt Section 4-10 of the Illinois HMO Act "is very probably unsound." App. 24a.

Section 514(a) of ERISA, the statute's "express preemption clause," *Boggs* v. *Boggs*, 520 U.S. at 841, broadly states that ERISA shall supersede all State laws to the extent they "relate to" any employee benefit plan. 29 U.S.C. § 1144(a). And it is well established in this Court's cases that ERISA preempts "any state law that refers to or has a connection with covered benefit plans." *Greater Washington*, 506 U.S. at 129-130. "This reading is true to the ordinary meaning of 'relate to,' and thus gives effect to the 'deliberately expansive' language chosen by Congress." *Id.* at 129 (citation omitted) (quoting *Pilot Life*, 481 U.S. at 46).

In the court below, respondents did not dispute that Section 4-10 relates to ERISA plans. *See* App. 15a ("We agree with the parties that § 4-10 of the HMO Act 'relates to' ERISA plans"); App. 25a (Posner, J.) ("The state law is conceded to relate to ERISA plans"). *See also* Amicus Br. of the Secretary of Labor 5 ("Section 4-10 of the Illinois HMO Act does 'relate to' ERISA plans."). Therefore, Section 4-10 may be saved from preemption only if it "regulates insurance" within the meaning of ERISA's savings clause, Section 514(b)(2)(A). 29 U.S.C. § 1144(b)(2)(A).

It does not. As a common sense matter, Section 4-10 "is not a general regulation of insurance, or even of health in-

surance; it is a regulation of HMOs." App. 25a (Posner, J.). Section 4-10 applies to "[e]ach Health Maintenance Organization," 215 Ill. Comp. Stat. 125/4-10, whether the HMO is acting as an insurer or merely the administrator of a benefit plan as to which another entity bears the risk.

Applying the first McCarran-Ferguson factor, Section 4-10 does not have the effect of spreading a policyholder's risk—a point the panel below did not dispute. *See* App. 18a n.3; *see also Corporate Health*, 215 F.3d at 538 (Texas independent review provisions "probably do not meet the first factor of reallocating the risk between the insured and the insurer"). With or without Section 4-10, medical necessity remains the substantive standard (along with other certificate coverages and exclusions) for determining whether the risk of paying for a procedure shall be borne by the HMO or the plan participant.

Section 4-10 also fails to satisfy the final McCarran-Ferguson factor. Section 4-10 is not limited to entities within the insurance industry because HMOs are subject to Section 4-10 even when they perform "administrative services only" roles and do not act as insurers.

Because both the common sense test and two of the three McCarran-Ferguson factors cut against deeming Section 4-10 a regulation of insurance, Section 4-10 is not saved from preemption. In such a case, there is no need to consider whether under the second McCarran-Ferguson factor Section 4-10 is an integral part of the policy relationship between the insurer and the insured. *Cf. Ward*, 526 U.S. at 367-375 (state rule saved since it satisfied the common sense test and the second and third McCarran-Ferguson factors).

But even if Section 4-10 does regulate insurance, the "analysis does not end [t]here," *Corporate Health*, 215 F.3d at 538, because under this Court's *Pilot Life* decision Section 4-10 would still be preempted on the ground that it conflicts with ERISA's exclusive civil enforcement mechanism—as

with ERISA's exclusive civil enforcement mechanism—as the Fifth Circuit and the four dissenting Seventh Circuit judges concluded. *See id.* at 539 (Texas independent review "scheme creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan" in "conflict with ERISA's exclusive remedy"); App. 25a (Posner, J.) (Section 4-10 "establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans.") (citing Section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B)).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 99-2574

DEBRA C. MORAN, PLAINTIFF-APPELLANT,

AND

STATE OF ILLINOIS, INTERVENOR-APPELLANT,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT-APPELLEE.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division
No. 98 C 442—Suzanne B. Conlon, Judge

Argued April 18, 2000
Decided Oct. 19, 2000

Before: FLAUM, *Chief Judge*, RIPPLE and WILLIAMS, *Circuit Judges*.

RIPPLE, *Circuit Judge*.

Section 4-10 of Illinois' Health Maintenance Organization Act ("the HMO Act"), 215 ILL. COMP. STAT. ANN. 125/1-1 *et seq*., requires HMOs to submit to an independent physician review when there is a disagreement over whether a course of treatment is medically necessary between a patient's primary care physician and the HMO. In the event

that the independent reviewer determines that the treatment is necessary, the HMO is required under § 4-10 of the HMO Act to cover the treatment.

Debra Moran's primary care physician recommended a specific surgery for her, but Rush Prudential HMO, Inc. ("Rush"), the service provider for Ms. Moran's ERISA-governed medical benefits plan, denied coverage for that surgery. Rush offered instead to cover a less expensive surgery to be performed by a Rush-affiliated doctor. At her own expense, Ms. Moran underwent the surgery proposed by her physician. She later sought to enforce her rights under § 4-10 of the HMO Act by bringing an action in state court. Rush removed the action to federal district court on ERISA preemption grounds. After additional proceedings, including a remand to state court and another removal by Rush, the district court granted summary judgment to Rush. The district court determined that § 4-10 of the HMO Act, and Ms. Moran's claims based on that act, were preempted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*. The district court also concluded, upon reviewing Rush's decision to deny coverage, that Rush's denial of coverage was not improper. Ms. Moran now appeals.[1] For the reasons set forth in the following opinion, we reverse the judgment of the district court.

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[1] The State of Illinois has intervened to defend the HMO Act. We also have the benefit of three *amicus curiae* briefs: one from the United States Department of Labor; one from the American Medical Association, the Illinois State Medical Society, and the American College of Legal Medicine; and one from the Illinois State Chamber of Commerce and the Employment Law Council of Illinois.

I

BACKGROUND

A.

Ms. Moran is covered by a medical benefits plan sponsored by her husband's employer. The plan is governed by ERISA, and it is fully insured. Rush is the HMO provider for the plan. Two aspects of the plan are worth noting. First, the plan's member certificate delegates to Rush "the broadest possible discretion" to interpret the terms of the plan and to determine which benefits the participants are entitled to receive. R.1-1, Ex. A. at 7. Second, the certificate provides that services that are not "medically necessary" will not be covered by the plan. *Id.* at 21.[2]

B.

Starting in 1996, Ms. Moran began experiencing pain, numbness, loss of function, and decreased mobility in her right shoulder. Ms. Moran sought treatment for these symptoms from Dr. Arthur LaMarre, her primary care physician and a Rush-affiliated physician. At first Dr. LaMarre treated

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[2] The plan documents provide that a service is "medically necessary" if Rush determines that it meets all of the following criteria:

(a) It is furnished or authorized by a Participating Doctor for the diagnosis or the treatment of a Sickness or Injury or for the maintenance of a person's good health.

(b) The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that its omission would adversely affect the person's medical condition.

(c) It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service . . . .

R.1-1, Ex. A at 21.

Ms. Moran through physiotherapy and other conservative therapies, but these efforts did not relieve her symptoms. While she was undergoing these conservative therapies, Ms. Moran obtained the name of Dr. Julia Terzis, an out-of-network surgeon in Virginia who specializes in microreconstructive surgery. After Rush denied Ms. Moran's request for a out-of-network referral to consult with Dr. Terzis, Ms. Moran traveled on her own accord to Virginia to be examined by Dr. Terzis. Dr. Terzis diagnosed Ms. Moran with brachial plexopathy and thoracic outlet syndrome ("TOS"), a nerve compression syndrome caused by the compression of nerves in Ms. Moran's brachial plexus.

Most nerve compression syndromes are mild and effectively treated with conservative physiotherapy, and surgery is not indicated unless more conservative measures fail to manage the symptoms. If surgery becomes necessary, the standard procedure for TOS involves decompression by way of first rib resection (the complete removal of the uppermost rib) or first rib resection with scalenectomy (the removal of the rib and the attached muscle). If necessary, a surgeon may use loupe magnification, in which the surgeon wears a goggle-like apparatus to magnify the immediate view, to conduct a neurolysis, which is removal of scar tissue surrounding the injured nerve. Dr. Terzis, however, performs a more complicated surgery for patients with Ms. Moran's condition. Dr. Terzis' surgery consists of rib resection, extensive scalenectomy, and, if indicated, microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification. Dr. Terzis concluded that Ms. Moran was a candidate for the more complicated microneurolysis surgery. She also indicated to Ms. Moran that she had successfully treated other patients with Ms. Moran's condition.

After meeting with Dr. Terzis, Ms. Moran asked Dr. LaMarre to obtain approval from Rush for Dr. Terzis' proposed surgery. Dr. LaMarre first had Ms. Moran see two Rush-affiliated thoracic surgeons, Dr. Raymond A. Dieter and Dr. William H. Warren. After examining Ms. Moran, both doctors confirmed Dr. Terzis' diagnosis of TOS and recommended that Ms. Moran undergo the standard TOS surgery. Ms. Moran, however, was not impressed by the prognosis offered by these doctors, and she decided that she wanted to have Dr. Terzis perform her proposed surgery.

On October 14, 1997, Dr. LaMarre asked Rush to approve Dr. Terzis' microneurolysis surgery for Ms. Moran. In his recommendation letter, Dr. LaMarre stated that, in his opinion, Ms. Moran would be "best served" by having Dr. Terzis' procedure performed. R.45, Ex. 5. Rush denied approval on the grounds that Dr. Terzis' surgery was out of network. Ms. Moran appealed the administrator's decision. In response to her appeal, Rush requested additional information from Dr. Dieter and Dr. Warren about Dr. Terzis' proposed surgery and the need for microneurolysis. Both doctors reported that microneurolysis was unnecessary for Ms. Moran. After reviewing the reports of Dr. Dieter and Dr. Warren, and after conducting its own analysis of relevant medical literature, Rush affirmed its denial of coverage for Dr. Terzis' microneurolysis surgery on the ground that the procedure was not "medically necessary" as defined by the plan. In a letter to Ms. Moran, Rush provided a detailed discussion of its reasons for denying coverage for Dr. Terzis' proposed surgery and informed Ms. Moran that it would cover the standard TOS surgery, by a network surgeon, of first rib resection with scalenectomy. Ms. Moran then made a final appeal to Rush's Membership Advisory Committee, but the committee voted to uphold Rush's denial.

The next month, in February 1998, Ms. Moran underwent Dr. Terzis' microneurolysis surgery. The surgery took nearly 14 hours and, with post-operative care, cost $94,841.27. Ms. Moran paid for the surgery herself. Ms. Moran submitted a copy of the bill for her surgery to Rush, and she and Dr. Terzis also submitted other materials related to the surgery. Rush treated these submissions as a renewed benefits claim, and it opened another investigation into whether Ms. Moran's now-completed surgery should be covered.

As part of its investigation, Rush sought the opinions of additional experts, and it provided these experts with Ms. Moran's medical records as well as information concerning Dr. Terzis' microneurolysis surgery. The first two opinions obtained by Rush were from Dr. Gerald Harris and Dr. John C. Alexander. These doctors were skeptical of the need for microneurolysis in Ms. Moran's case, but they admitted that they lacked expertise in the area. Rush next consulted with Dr. Susan E. MacKinnon, the Chief of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis. Dr. MacKinnon opined that Dr. Terzis' microneurolysis was unnecessary.

C.

In January 1998, the month before she underwent surgery, Ms. Moran made a written demand to Rush for it to comply with § 4-10 of the HMO Act. Under the Act, HMOs are required to provide a mechanism for a review by an independent physician when the patient's primary care physician and HMO disagree about the medical necessity of a treatment proposed by the primary care physician. *See* 215 ILL. COMP. STAT. ANN. 125/4-10. Section 4-10 further provides that the HMO must provide the proposed treatment in the event that the reviewing physician determines that it is medically necessary. *See id.* Rush did not act on Ms.

Moran's request, and Ms. Moran then filed a complaint in Illinois circuit court seeking a court order requiring Rush to appoint an independent physician to review her claim. Rush removed the action to federal district court on the ground that ERISA completely preempts Ms. Moran's claim.

The district court remanded the case to the state court. The court noted that preemption is generally a defense and that, under the well-pleaded complaint rule, an anticipated federal defense could not be the basis for removal. Nonetheless, the district court also noted that a "completely preempted" state law claim could be removed, but the court explained, in the ERISA context, only state law claims that conflicted with ERISA's civil enforcement provisions were completely preempted by ERISA. In this case, the district court concluded, Ms. Moran's request for specific performance was not a claim under ERISA's civil enforcement provisions and therefore was not completely preempted. The district court left open the possibility that a claim for reimbursement under § 4-10 of the HMO Act, in contrast to a request to have the independent review performed, might be a claim for benefits that would be completely preempted by ERISA's civil enforcement provisions.

D.

Upon remand, the state court ordered Rush to submit to the independent physician review mandated by the HMO Act. The state court reserved ruling on whether ERISA preempted the portion of § 4-10 that requires the HMO to cover the procedure in the event that the independent physician determines the procedure is medically necessary. Rush and Ms. Moran agreed to have Dr. A. Lee Dellon, an expert in plastic and reconstructive surgery at Johns Hopkins Medical Center, perform the independent review. After reviewing Ms. Moran's case and the details of the surgery performed by Dr.

Terzis, Dr. Dellon concluded that the surgery was medically necessary, including the microneurolysis. Dr. Dellon, however, reported that he would have used loupe magnification, instead of Dr. Terzis' technique, to perform the neurolysis. The procedure proposed by Dr. Dellon would have been less intrusive and less time consuming than the one performed by Dr. Terzis. After Dr. Dellon had completed his independent review, Rush concluded its renewed investigation into whether Ms. Moran's surgery should be covered. Rush's medical director, after reviewing the reports of Dr. MacKinnon and Dr. Dellon along with the reports of the other doctors, concluded that Dr. Terzis' surgery had not been medically necessary. In January 1999, Rush again denied Ms. Moran's benefits claim.

E.

Following the independent review by Dr. Dellon, Ms. Moran asked the state court to require Rush to reimburse her for the surgery. The state court requested that Ms. Moran amend her complaint to clarify the relief she was seeking. Ms. Moran then filed an amended complaint, the First Amended Complaint, seeking enforcement of § 4-10 of the HMO Act and reimbursement for the surgery in the amount of $94,841.27.

After Ms. Moran filed her First Amended Complaint, Rush removed the suit to federal court once again. This time, Rush argued that Ms. Moran's suit was a claim for benefits that was completely preempted and that her claim, therefore, had to be made under ERISA's civil enforcement provision, § 502(a), 29 U.S.C. § 1132(a). Ms. Moran argued that removal was improper because her claim for reimbursement was a state law claim. The district court, relying on our decision in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996), held that Ms. Moran's claim for

reimbursement properly was recharacterized as a claim for benefits, which meant that her claim was completely preempted because it fell within § 502(a)(1)(B) of ERISA's civil enforcement provision.

Turning to the merits, the district court then addressed Rush's contention that ERISA preempted § 4-10 of the HMO Act and that, therefore, its provisions did not cabin the discretion of the administrator. The court held that ERISA's "saving clause" did not apply because § 4-10 did not meet one of the *McCarran-Ferguson* factors used to determine whether a law regulates insurance for purposes of that clause. According to the district court, § 4-10 of the HMO Act did not transfer or spread policyholders' risk.

Ms. Moran subsequently moved for reconsideration of the district court's ruling. Ms. Moran argued that the district court should reconsider its previous decision in light of the Supreme Court's opinion in *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999). In *Ward*, the Supreme Court held that a state law need not satisfy all three *McCarran-Ferguson* factors in order for the law to fall within ERISA's saving clause. *See id.* at 374. The district court denied Ms. Moran's motion for reconsideration on the ground that, even if the saving clause saved § 4-10 from preemption, § 4-10 was preempted nonetheless because it fell within the "deemer clause" exception to the saving clause. Under the deemer clause, the district court held, ERISA preempted § 4-10 of the HMO Act "[b]ecause the Illinois HMO Act has the effect of directly regulating employee benefit plans rather than an insurance company." R.53.

F.

Ms. Moran amended her complaint a second time in April 1999, ostensibly to state a claim for reimbursement under § 4-10 of the HMO Act and to avoid stating a claim for

benefits under ERISA. In the alternative, the Second Amended Complaint also alleged ERISA claims under § 502(a)(1)(B) for breach of contract and for breach of fiduciary duty. The parties then filed cross motions for summary judgment, and the district court granted summary judgment to Rush. The district court explained that, regardless of Ms. Moran's efforts to plead only state law claims, she still was making a claim for benefits under § 502(a)(1)(B) because she was seeking reimbursement for her surgery. Proceeding to its analysis of Ms. Moran's claim for benefits, the district court noted that the certificate governing Ms. Moran's benefits gave Rush the "broadest possible discretion" to interpret the plan's terms and to make benefits determinations. R.79 at 10 (citation omitted). Given the standard of review for plans bestowing this kind of discretion, the district court held that Rush was entitled to summary judgment because it had not abused its discretion or acted arbitrarily in denying Ms. Moran's claim for benefits.

II

DISCUSSION

A.

A district court's preemption ruling is a question of law that we review *de novo*. *See Carpenters Local Union No. 26 v. United States Fidelity & Guar. Co.*, 215 F.3d 136, 139 (1st Cir. 2000); *Burlington N. & Santa Fe Ry. v. Doyle*, 186 F.3d 790, 794 (7th Cir. 1999). We also review *de novo* the propriety of the removal of a state action to federal court. *See Tylka v. Gerber Prods. Co.*, 211 F.3d 445, 447 (7th Cir. 2000). Likewise, we review *de novo* a district court's grant of summary judgment. *See Anstett v. Eagle-Picher Indus., Inc.*, 203 F.3d 501, 503 (7th Cir. 2000). It is appropriate to grant summary judgment only when "the pleadings, depositions, answers to interrogatories, and admissions on file,

together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *see Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986).

B.

A defendant may remove to federal court actions originally brought in a state court only when those actions fall within the federal court's original jurisdiction, *see* 28 U.S.C. § 1441(a), which would include "federal question" jurisdiction over cases "arising under the Constitution, laws, or treaties of the United States," 28 U.S.C. § 1331. Ms. Moran maintained throughout the proceedings in the district court that removal was improper because her claims based on § 4-10 of the HMO Act do not arise "under the Constitution, laws, or treaties of the United States." Ms. Moran also makes this argument on appeal.

As we explained in *Speciale v. Seybold*, 147 F.3d 612 (7th Cir.), *cert. denied*, 525 U.S. 1017 (1998), "[t]he determination of jurisdiction on removal involving an ERISA issue is based upon the well-pleaded complaint rule, the ERISA 'complete preemption' exception to that rule and the defense of 'conflict preemption' under ERISA." *Id.* at 614. Under the well-pleaded complaint rule, we look to the state court complaint and not to the defendant's response to determine whether the plaintiff's claim falls under federal question jurisdiction. *See, e.g., Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1486 (7th Cir. 1996). "It is long settled law that a cause of action arises under federal law only when the plaintiff's well-pleaded complaint raises issues of federal law." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 63 (1987). A defendant's federal defense to a claim arising under state law, therefore, "does not create federal jurisdic-

tion and therefore does not authorize removal." *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 495 (7th Cir.), *cert. denied*, 522 U.S. 997 (1997).

There exists, however, an exception to the well-pleaded complaint rule for state law claims that have been "completely preempted" by Congress. *See Speciale*, 147 F.3d at 615. This so-called "complete preemption" doctrine really "is not a preemption doctrine but rather a federal jurisdiction doctrine." *Lister v. Stark*, 890 F.2d 941, 943 n.1 (7th Cir. 1989). Even though a complaint may not mention a federal basis of jurisdiction, the complete preemption doctrine "permits 'recharacterization' of a plaintiff's state law claim as a federal claim so that removal is proper." *Speciale*, 147 F.3d at 615 (quoting *Lister*, 890 F.2d at 943).

In *Metropolitan Life*, the Supreme Court held that the civil enforcement provision of ERISA, § 502(a), completely preempts state law causes of action that fall within the scope of that provision. *See* 481 U.S. at 67; *Speciale*, 147 F.3d at 615. One of ERISA's civil enforcement provisions, § 502(a)(1)(B), allows a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B).

In *Jass*, we identified three factors to be used to determine whether a state law claim should be recharacterized as an ERISA claim under § 502(a): (1) "whether the plaintiff is eligible to bring a claim under that section"; (2) "whether the plaintiff's cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a)"; and (3) "whether the plaintiff's state law claim cannot be resolved without an interpretation of the contract governed by federal law." 88 F.3d at 1487 (quotation marks and citations omitted). When all three factors are present, the state law claim is properly recharacterized as an ERISA claim under § 502(a). *See id.* at 1489-90.

We agree with the district court that Ms. Moran's state law claims are properly recharacterized as claims for benefits under § 502(a)(1)(B) of ERISA and, therefore, are completely preempted. Ms. Moran's claims certainly satisfy the first two *Jass* factors. First, she is a plan participant and is, therefore, eligible to bring an action under § 502(a)(1)(B). Second, she is seeking to enforce her right to a benefit under her plan. Ms. Moran seeks payment for the surgery. Finally, Ms. Moran's claims meet the third *Jass* factor because they require an interpretation of the insurance contract governing Ms. Moran's right to the independent review. As we explained in *Plumb v. Fluid Pump Serv., Inc.*, 124 F.3d 849 (7th Cir. 1997), Illinois laws automatically are incorporated into all contracts of insurance in that state. *See id.* at 861. Thus, the provisions of § 4-10 of the HMO Act have been incorporated into Ms. Moran's insurance contract. Therefore, the extent and the enforceability of Ms. Moran's right to an independent review necessarily requires an examination of the contract. Thus, Ms. Moran's claims properly are recharacterized as claims for benefits under ERISA's civil enforcement provision, § 502(a)(1)(B), and removal was proper.

C.

Now that we have determined that removal of Ms. Moran's state court claims based on § 4-10 of the HMO Act was proper, we turn to Rush's preemption defense.

The comprehensive scope of ERISA extends to the regulation of employee welfare benefit plans providing "medical, surgical, or hospital care or benefits" for plan participants "through the purchase of insurance or otherwise." 29 U.S.C.

§ 1002(1); *see New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51 (1995). As the Supreme Court explained in *Travelers*, ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits." *Travelers*, 514 U.S. at 651. Rather, the statute "controls the administration of benefit plans." *Id.* "It envisions administrative oversight, imposes criminal sanctions, and establishes a comprehensive civil enforcement scheme." *Id.*

As provided by § 514 of the statute, ERISA also preempts some state laws. Specifically, ERISA's preemption clause, § 514(a), "broadly" states that state laws are preempted "to the extent that those laws 'relate to any employee benefit plan.' " *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 363 (1999) (quoting § 514(a), 29 U.S.C. § 1144(a)). Section 514, however, contains a saving clause, § 514(b)(2)(A), which qualifies § 514(a) by excepting state laws from preemption when those laws "regulate[ ] insurance." 29 U.S.C. § 1144(b)(2)(A); *see Ward*, 526 U.S. at 367. Still another clause in § 514 serves as an exception to the saving clause exception: the deemer clause, § 514(b)(2) (B), "makes clear that a state law that 'purports to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987) (quoting § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B)).

We address each clause in turn.

1.

For purposes of § 514(a), a state law "relates to" a covered employment benefit plan if it either has (1) "a connection with" or (2) "reference to" such a plan. *E.g.*, *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997); *Travelers*, 514 U.S. at 656;

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983). We agree with the parties that § 4-10 of the HMO Act "relates to" ERISA plans because its provisions have a connection with such plans.

To determine whether § 4-10 of the HMO Act "relates to" ERISA plans, we begin by looking at the state statute. Section 4-10 provides, in relevant part:

> Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.

215 ILL. COMP. STAT. ANN. 125/4-10. From the text of the HMO Act it is apparent that the law does not make "reference to" an ERISA-governed employee benefit plan; no mention is made of ERISA plans, and the law applies to HMOs regardless of whether a patient's coverage is through an ERISA plan. *Cf. Travelers*, 514 U.S. at 656 (noting that the law in question in that case did not make "reference to" ERISA plans because the law's provisions applied regardless of whether the coverage was "secured by an ERISA plan, private purchase, or otherwise").

State laws that "risk subjecting [ERISA] plan administrators to conflicting state regulations" undoubtedly have a "connection with" ERISA plans within the meaning of § 514(a). *FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990). Here, § 4-10 of the HMO Act requires HMOs, including those that are service providers for ERISA plans, to provide an independent review mechanism and, should the independent reviewer agree with the primary care physician, to pay claims that otherwise might not be paid under the plan. As the Court explained in *Travelers*, state laws that "mandate[] employee benefit structures or their administration" fall within the ambit of ERISA's preemption clause. *Travelers*, 514 U.S. at 658. Section 4-10 of the HMO Act has an effect on how benefit determinations are made and, thus, squarely falls within ERISA's preemption clause.

2.

As we already have noted, however, a state law that "relates to" ERISA plans may nonetheless avoid preemption if that law "regulates insurance" within the meaning of ERISA's saving clause, § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). *See Ward*, 526 U.S. at 363. To determine whether a state law "regulates insurance" within the meaning of the saving clause, we first ask "whether, from a 'common-sense view of the matter,' the contested prescription regulates insurance." *Id.* at 367 (quoting *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985)). Next, we consider "three factors employed to determine whether the regulation fits within the 'business of insurance' as that phrase is used in the McCarran-Ferguson Act." *Id.* (citing 15 U.S.C. § 1011 *et seq.*). Of these three factors, the first is "whether the practice has the effect of transferring or spreading a policyholder's risk." *Id.* (quotation marks and citation omitted). The second factor is "whether the practice is an integral part of the policy relationship between the

insurer and the insured." *Id.* (quotation marks and citation omitted). And the third is "whether the practice is limited to entities within the insurance industry." *Id.* (quotation marks and citation omitted). A state law may fall within the saving clause even if it cannot satisfy all three of the *McCarran-Ferguson* factors. *See id.* at 373-74 (stating that the *McCarran-Ferguson* factors are "guideposts" and rejecting the argument that all three are required).

We conclude that § 4-10 of the HMO Act falls within the saving clause because it "regulates insurance" under a common sense understanding and because it meets at least two of the McCarran-Ferguson factors. As a matter of common sense, § 4-10 of the HMO Act regulates insurance because the law is directed at the HMO industry as insurers. We previously have explained that HMOs "are insurance vehicles under Illinois law," *Anderson v. Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994), and § 4-10 of the HMO Act is aimed exclusively at members of the insurance industry, even if the law does not affect the entire insurance industry in Illinois.

Section 4-10 of the HMO Act further regulates insurance under a common sense understanding because the Act's provisions go to the core of the relationship between the insurer and the insured. "It is fundamental insurance law that 'existing and valid statutory provisions enter into and form a part of all contracts of insurance to which they are applicable, and, together with settled judicial constructions thereof, become a part of the contract as much as if they were actually incorporated therein.' " *Plumb*, 124 F.3d at 861 (quoting 2 Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d § 19:1, at 19-2 to 19-4 (1996)). The provisions of § 4-10 of the HMO Act, therefore, are substantive terms of all insurance policies in Illinois by operation of law. When a law mandates a contract term between parties, whether that term

is characterized as creating a "procedural" or "substantive" right, that law is "integral" to the insurer/insured relationship. *Ward*, 526 U.S. at 374-75 & n.5.

Having determined that § 4-10 of the HMO Act regulates insurance under a common sense understanding, we look next to the *McCarran-Ferguson* factors. Section 4-10 clearly satisfies the second and third *McCarran-Ferguson* factors.[3] The second *McCarran-Ferguson* factor is satisfied because § 4-10 creates a mandatory term in the insurance contract and, thus, "changes the bargain between insurer and insured," *id.* at 374. Moreover, § 4-10 satisfies the third *McCarran-Ferguson* factor because, as we already have explained, the section applies only to HMOs acting as insurers. Thus, the law is limited to entities within the insurance industry.

3.

The "deemer clause," § 514(b)(2)(B), is an exception to the saving clause exception. A law saved from preemption by the saving clause may still be preempted if it falls within the deemer clause. *See FMC Corp.*, 498 U.S. at 61. Under this clause, state laws that purport to regulate insurance by "deeming" a plan to be an insurance company are outside of the saving clause and are subject to preemption. *See id.*

The "deemer clause" is inapplicable to this case. In *FMC Corp.*, the Supreme Court explained that the deemer clause exempts "self-funded ERISA plans from state laws that 'regulate insurance' within the meaning of the saving clause." *Id.* The ERISA plan at issue before us, however, is not a self-funded plan; it is an insured plan. The Supreme Court's interpretation of the deemer clause "makes clear that

[3] Because at least two of the *McCarran-Ferguson* factors are secured, we need not decide whether § 4-10 of the HMO Act transfers or spreads risk. *Cf. Ward*, 526 U.S. at 374.

if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *Id.* at 64. Rush is the insurer to the ERISA plan at issue in our case, and therefore the deemer clause does not apply. *See Ward*, 526 U.S. at 367 n.2 (stating that, because the plan at issue in that case was not self-insured, the deemer clause was "not at issue"); *Plumb*, 124 F.3d at 859 n.6 (explaining that, because the plan at issue was an insured plan, the deemer clause was inapplicable).

4.

A state law that falls within the saving clause nevertheless may be preempted if that law conflicts with a substantive provision of ERISA. *See Pilot Life*, 481 U.S. at 57. Rush argues that § 4-10 of the HMO Act conflicts with § 502(a)(1)(B) of ERISA's civil enforcement scheme. That provision establishes the right of plan participants or beneficiaries to sue "to recover benefits" under the plan, "to enforce . . . rights" under the plan, or "to clarify . . . rights" under the plan. 29 U.S.C. § 1132(a)(1)(B). Rush invites our attention to a decision from the Court of Appeals for the Fifth Circuit, *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, 215 F.3d 526 (5th Cir. 2000), in which the court considered an independent review statute from Texas that is quite similar to § 4-10 of Illinois' HMO Act.

The Texas independent review statute, like §4-10 of the HMO Act, essentially "allow[s] a patient who has been denied coverage to appeal to an outside organization." *Id.* at 537. The law requires HMOs to provide a mechanism for patients to obtain an independent review of the need for a course of treatment. Specifically, the court explained, the Texas statute states that patients may appeal "adverse determinations," which are defined as determinations that a health care service is not "medically necessary" or "appropriate," to

an independent reviewer. *Id.* (quotation marks and citations omitted). Moreover, under the Texas statute, the HMO must "comply" with the independent reviewer's determination of medical necessity. *Id.* (quotation marks and citation omitted).

Our colleagues in the Fifth Circuit took the view that the Texas law conflicted with ERISA's civil enforcement scheme and therefore was preempted. The court concluded that Texas' independent review statute was preempted, even though it regulated insurance within the meaning of the saving clause, because the statute's provisions were contrary to the civil enforcement scheme established in § 502(a). *See id.* at 539. According to the court, the Texas independent review statute "establish[ed] a quasi-administrative procedure for the review of [a decision to deny benefits] and [bound] the ERISA plan to the decision of the independent [reviewer]." *Id.* "This scheme," the court held, "creates an alternative mechanism through which plan members may seek benefits due them under the terms of the plan—the identical relief offered under [§ 502(a)(1)(B)]." *Id.*

In denying the petition for rehearing, the court further explained that, in its view, the Texas' independent review provision "substitutes the medical judgment of a third party physician for the HMO's, or treating physician's, judgment as to medical necessity." *Corporate Health Ins. Co. v. Texas Dep't of Ins.*, 220 F.3d 641, 644 (5th Cir. 2000). In the view of the court, "the law is clear that Texas cannot provide a supplementary claims process by binding the HMO to pay for a treatment that is simply a second opinion on medical necessity about which reasonable doctors might reach differing conclusions." *Id.* at 645. Although the court left open the possibility that an independent review statute might not run afoul of the exclusivity of ERISA's civil enforcement provisions if the independent review mechanism "regulate[d]

the minimal quality level of medical care provided for covered conditions," the court explained that the Texas statute was "plainly a state regime for reviewing benefit decisions and not a system for implementing a mandated term of insurance regulating a minimal standard of care." *Id.*

In our view, § 4-10 of the Illinois HMO Act cannot be characterized as creating an alternative remedy scheme that conflicts with § 502(a). The independent review scheme created by the Illinois statute is not tantamount to the relief offered under § 502(a)(1)(B). As we already have explained, the provisions of § 4-10 of the HMO Act have been incorporated into Ms. Moran's insurance contract.[4] Thus, a suit by her to enforce the HMO Act's provisions is simply a suit to enforce the terms of the plan—precisely the sort of suit that is contemplated by § 502(a)(1)(B) "to enforce rights" and "to recover benefits" under the plan. Notably, the "sole launching ground" for Ms. Moran's claims to enforce § 4-10 of the HMO Act remains § 502(a). *Ward*, 526 U.S. at 377.[5] Rather than providing an alternative remedy for Ms. Moran to recover benefits, § 4-10 of the HMO Act simply establishes an additional internal mechanism for making decisions about

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[4] Indeed, aside from the fact that the Illinois statute automatically became part of the contract by operation of law, the certificate defining Ms. Moran's rights under the plan incorporated the provisions of § 4-10 of the HMO Act. Specifically, the certificate provides that "[i]f the provisions of this Certificate do not conform to the requirements of any state or federal law that applies to the Certificate, the Certificate is automatically changed to conform with the requirements of that law." R.1-1, Ex. A, at 34.

[5] Although Ms. Moran's pleadings in this litigation purported to assert claims under state law, we already have explained that her claims premised on § 4-10 of the HMO Act must be recharacterized as claims made under § 502(a)(1)(B).

medical necessity and identifies who will make that decision in those instances when the HMO and the patient's primary care physician cannot agree on the medical necessity of a course of treatment. Rather than eliminate the review procedures established by the plan, it simply adds to the contract, by operation of law, an additional dispute resolving mechanism when, despite exhausting the internal review system otherwise provided by the plan, there remains a disagreement between the plan's own experts and the attending physician on the issue of medical necessity.

Nor does the addition of this statutorily mandated provision in the contract alter impermissibly the deferential standard of review required by the language of the plan. Certainly, the administrator's failure to abide by the decision of the outside medical consultant on the issue of medical necessity would constitute an abuse of discretion. The statutorily required provision of the plan requires that the decision of the independent review physician be followed, and it would be an abuse of discretion on the part of the administrator not to observe the command of this provision. However, the different outcome is not because of a change in the standard of review but because of a change in the provisions of the contract.[6]

We also believe that it is inaccurate to say that § 4-10 of the HMO Act conflicts with the fiduciary role of the administrator of the plan. At the outset, it is important to note that

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[6] We note that, in this case, the reviewing physician employed the definition of medical necessity found in the provisions of the plan. Although the parties do not bring the issue to us, and we therefore need not decide it, the use of the plan's definition demonstrates even further that § 4-10 of the HMO Act does not totally disrupt the pre-existing terms of the plan but merely affords the participant an additional protection.

the provisions of § 4-10 of the HMO Act apply only to disputes about whether a covered service is medically necessary in a given case. Other issues, most notably the issue of whether a particular treatment is covered, do not fall within the ambit of the section. Moreover, as we have already noted, even with respect to medical necessity decisions, there is nothing in § 4-10 of the HMO Act that in any way abrogates the pre-existing fiduciary obligations of the administrator. Section 4-10 of the HMO Act merely adds an additional obligation that the fiduciary must observe.

In sum, § 4-10 of the HMO Act requires entities in the business of insurance to provide additional safeguards to preserve the integrity of the decision-making process. Following the example of the Supreme Court of the United States, we believe that such requirements ought to be treated as mandated contract terms and treated as part of the insurance contract. *See Ward*, 526 U.S. at 375-76; *see also Plumb*, 124 F.3d at 861. Unlike the situation in *Pilot Life*, we are not asked here to recognize a state common law doctrine of general applicability but a specific statutory provision aimed at the regulation of the insurance industry. As in *Ward*, we simply accept the state-mandated provision as a provision of the plan and then enforce the contract.[7]

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[7] To the degree that our views differ from those of the Fifth Circuit, we find ourselves in respectful disagreement and therefore have circulated this opinion under Circuit Rule 40(e). The opinion has been circulated among all judges of this court in regular active service. A majority of the judges in active service did not wish to rehear the case en banc. Judges Posner, Coffey, Easterbrook and Diane P. Wood voted to grant rehearing en banc.

D.

In this case, there no longer remains a question of material fact that would preclude judgment as a matter of law. As we already have explained, Ms. Moran's claim for reimbursement really is a claim for benefits made under § 502(a)(1)(B) to enforce her rights under the plan. Moreover, § 4-10 of the HMO Act, as incorporated into the plan by operation of law, entitled Ms. Moran to the independent review conducted by Dr. Dellon. Dr. Dellon determined, in agreement with Ms. Moran's primary care physician, that the surgery performed by Dr. Terzis was "medically necessary." Thus, Ms. Moran is entitled to summary judgment in her favor.

Conclusion

For the foregoing reasons, we reverse the judgment of the district court.

REVERSED

POSNER, *Circuit Judge*, with whom *Circuit Judges* COFFEY, EASTERBROOK, and DIANE P. WOOD join, dissenting from denial of hearing en banc.

This case is well worth the attention of the full court. The panel's decision creates a square conflict with another circuit, is very probably unsound, and will affect an enormous number of cases. It is also a single-issue case, and the issue is one of law, so that en banc consideration would be unlikely to create a fractured result or bog the court down in factual questions. Rarely have we had so strong a candidate for en banc review.

The decision holds that ERISA does not preempt an Illinois statute that requires HMOs to submit to review by an independent physician the decision by the HMO not to cover a treatment deemed medically necessary by the patient's

physician. 215 ILCS 125/4-10. An ERISA medical-benefits plan sponsored by the employer of the plaintiff's husband had delegated the provision of the services to which the plan participants were entitled to an HMO. The plan did not require the HMO to submit disagreements with a plan participant's doctor to arbitration by an independent third party. The Illinois statute, unless preempted by ERISA insofar as the statute's application to ERISA plans is concerned, will thus effect a substantial change in the employer's plan. The state law is conceded to relate to ERISA plans and so it is preempted unless the law merely regulates insurance. *See* 29 U.S.C. §§ 1144(a), (b)(2)(A). In *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999), the principal basis for the panel's decision, the Supreme Court held that a state law that limited insurance companies' right to ignore late claims when the lateness did not harm the insurance company merely regulated insurance and therefore could lawfully be applied to ERISA plans. As the Fifth Circuit pointed out in the decision with which the panel has gone into conflict, *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000), the "notice prejudice" law held not preempted in *Ward* was a typical regulation of insurance rather than anything either special to ERISA plans or likely to be mischievous in its impact on those plans. All the law provided was that an insurer couldn't disregard late claims unless it had been harmed by the lateness.

The law in this case, like the materially identical law held preempted by the Fifth Circuit, is not a general regulation of insurance, or even of health insurance; it is a regulation of HMOs, which are the service providers under a great many ERISA medical-benefits plans. The law establishes a system of appellate review of benefits decisions that is distinct from the provision in ERISA for suits in federal court to enforce entitlements conferred by ERISA plans. 29 U.S.C.

§ 1132(a)(1)(B). By doing so, the law interferes with the federally specified system for enforcing such entitlements. The suit for breach of contract envisaged by the statute becomes a suit for judicial review of the independent physician's decision. The Illinois law thus adds heavy new procedural burdens to ERISA plans. These burdens do not come without cost. The expense of an arbitration by the independent physician could easily equal the expense of the medical treatment that the HMO had refused to authorize. Piling on costs in the administration of ERISA plans will shrink benefits and deter some employers from offering health insurance at all. In addition, the Illinois law obviously is intended (responding to the recent torrent of criticisms of HMOs) to tilt the administration of those plans in favor of participants by giving them an additional remedy while not giving any additional remedy to the plan. The law undermines the statutory purpose of federal uniformity in the administration of ERISA plans. If such laws are permissible, the rights of participants in an ERISA plan will change as they are transferred by their employer from state to state, even though they are nominally under the same plan.

Although the panel's opinion is long, it does not respond to the concerns just expressed, although they were forcefully argued in the HMO's brief and in an amicus brief supporting the HMO. All that the panel can find to say in defense of its startling decision, except that it thinks it supported by *Ward*, yet without appreciating the force of the Fifth Circuit's distinction of that case, is that the Illinois law makes the physician-review provision a part of the ERISA plan and so does not disturb the exclusivity of ERISA's scheme for the enforcement of the rights that ERISA plans confer on participants and beneficiaries. Under the panel's view, then, if the plan does not submit a disagreement to review by the independent physician, the participant can sue the plan for a

violation of its terms. This is just a façon de parler. It invites states to evade the preemptive force of ERISA simply by deeming its regulations of ERISA plans to be plan terms. It would authorize a state to require ERISA plans to double their benefits. I am sure the panel would not go so far as to permit so transparent an evasion of ERISA's preemption clause, but the opinion contains nothing that would enable the panel to distinguish that case. Far from being compelled by *Ward*, the panel's opinion is in tension with *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), which it does not cite. Although *Pegram* held that combined treatment-eligibility decisions by an HMO are not fiduciary decisions under ERISA, it did not doubt that ERISA applied to HMO-managed ERISA plans; the panel, by contrast, seems to think ERISA inapplicable to such plans.

There is another unresolved tension in the panel's opinion. The opinion appears to depend on two propositions: first, that the Illinois law regulates insurance rather than ERISA plans and thus is not preempted; second, that by virtue of Illinois law the requirement of independent physician review is written not only into an insurance contract but also into the plan itself, which makes the requirement enforceable in federal court. The two propositions are incompatible. If the statute merely regulates insurance and therefore is not preempted, how can it be part of an ERISA plan and enforceable in federal court? If, on the other hand, the requirement imposed by the statute is and must be incorporated into the plan, then Illinois has done more than merely regulate the contents of an insurance policy. It has regulated the contents of an ERISA plan—which means that its law is preempted.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT.

No. 98 C 442

June 9, 1998

MEMORANDUM OPINION AND ORDER

SUZANNE B. CONLON, *Judge*.

Debra C. Moran ("Moran") filed a complaint for specific performance in the Circuit Court of Cook County against Rush Prudential HMO, Inc. ("Rush"). Moran suffers from brachial plexopathy and thoracic outlet syndrome. Rush denied coverage for a surgical procedure recommended by Moran's physician based on a plan exclusion for services "not medically necessary." Moran seeks independent physician review of the medical necessity of the surgical procedure pursuant to section 4-10 of the Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* ("the HMO Act"). On January 26, 1998, Rush removed the case to federal court on the grounds that Moran's state law claim was completely preempted by the Employment Retirement Income Security Act of 1974 ("ERISA), 29 U.S.C. § 1001 *et*

seq. Moran moves to remand this case to the Circuit Court of Cook County.

DISCUSSION

I. BACKGROUND PRINCIPLES

Federal question jurisdiction exists for claims "arising under" the Constitution, laws, or treaties of the United States. 28 U.S.C. § 1331. A cause of action arises under federal law when the plaintiff's well-pleaded complaint raises issues of federal law. *Gully v. First National Bank*, 299 U.S. 109 (1936). Federal courts do not have original jurisdiction over a state law claim only because a defense to the claim raises a federal issue. This is true even if the plaintiff anticipates the defense and pleads it in his complaint. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 14 (1983). Under the well-pleaded complaint rule, federal preemption of a state claim is generally a defense; while preemption may extinguish the state claim, it does not convert an otherwise state law claim to one "arising under" federal law. *See id.* Thus, federal preemption does not normally authorize removal of a case from state to federal court. *Id.*

II. ERISA AND COMPLETE PREEMPTION

The Supreme Court has recognized a limited exception to the well-pleaded complaint rule in cases of complete preemption. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Lister v. Stark*, 890 F.2d 941, 943 (7th Cir. 1989). This term is really a misnomer "since the complete preemption doctrine is not a preemption doctrine but rather a federal jurisdiction doctrine." *Lister*, 890 F.2d at 944 n.1; *Bartholet v. Reishauer A.G.*, 953 F.2d 1073, 1075 (7th Cir. 1992). The complete preemption doctrine overrides the general rule that "the plaintiff is master of [her] pleadings." *Bartholet*, 953 F.2d at 1075. Even if a complaint purports to raise only state

law claims, the state-law claims may be recharacterized as a federal claim so that removal is proper. *Taylor*, 481 U.S. at 64; *Lister*, 890 F.2d at 943. Recharacterization occurs when the preemptive force of a statute, as judged by Congress' intent, is so strong as to displace entirely all state law causes of action in the particular area. *See Taylor*, 481 U.S. at 63-67. In other words, in certain situations "federal law so fills every nook and cranny that it is not possible to frame a complaint under state law." *Bartholet*, 953 F.2d at 1075.

The parties dispute whether section 4-10 of the HMO Act falls outside the scope of complete preemption through application of ERISA's "savings clause," 29 U.S.C. § 1144(b)(2)(A). But before addressing that question, it is important to address whether Moran's state-law claim may be properly "recharacterized" in the first instance. Courts have been careful to distinguish complete preemption from the defense of preemption in the ERISA context. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . ." This type of preemption has been termed conflict preemption. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 145 (1990). But the mere fact ERISA preempts a state law cause of action does not mean that the state claim arises under federal law. *See Franchise Tax Bd.*, 463 U.S. at 25-27. "[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law" because the federal law serves only as a defense to the state law claims. *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995).

ERISA does not completely preempt a state law claim unless the claim falls within the scope of ERISA's civil enforcement provision, section 502(a). 29 U.S.C. § 1132; *Taylor*, 481 U.S. at 64-66. In particular, section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to

bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption permits removal "when the plaintiff's own claim "depends on ERISA, and the effort to craft a claim" under state law reflects artful pleading." *Blackburn v. Sunderstrand Corp.*, 115 F.3d 493, 495 (7th Cir. 1997). "If a state law claim has been 'displaced' and therefore completely preempted by § 502(a), then a plaintiff's state law claim is properly 'recharacterized' as one arising under federal law." *Rice*, 65 F.3d at 640 (citations omitted).

Although the defense of conflict preemption does not confer subject matter jurisdiction, there is a noted interrelationship between a finding of complete preemption under § 502(a) and conflict preemption under § 514(a) and conflict preemption under § 514(a). *Rice*, 65 F.3d at 646 n.10. "Where a claim is completely preempted under § 502(a) it is necessarily preempted under § 514(a)." *Id.* But the converse does not hold true, for not every state claim related to ERISA under § 514(a) is completely preempted.

The Seventh Circuit recently identified three factors pertinent to the question of complete preemption under § 502(a). These factors are: "(1) whether the 'plaintiff [is] eligible to bring a claim under that section;' (2) whether the plaintiff's 'cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a);' and (3) whether the plaintiff's 'state law claim cannot be resolved without an interpretation of a contract governed by federal law.' " *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). When all three factors are present, a state-law claim is properly recharacterized as an ERISA section 502(a) claim. *Id.* at 1489. There is no apparent dispute as to the first factor of the *Jass* analysis. Thus, the court looks to

the second and third factors to determine whether Moran's claim is properly recharacterized as a federal claim.

Even assuming the second *Jass* factor is satisfied, the court is unconvinced that the third factor is satisfied in this case. Moran seeks specific performance of the requirements of Section 4-10 of the HMO Act. Section 4-10 of the HMO Act provides as follows:

> Medical Necessity—Dispute Resolution—Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service.

215 ILCS § 125/4-10.

Rush argues that Moran's state-law claim cannot be resolved without interpreting plan language—specifically, the meaning of the plan exclusion for "Services or Supplies Not medically Necessary." Rush reasons that "nothing in section 4-10 [suggests] the plan beneficiary has the right to have the independent reviewer (1) ignore 'medical necessity' plan language and (2) apply a definition of 'medical necessity' different than that contained in the plan itself." Resp. at 7. Putting to one side the question whether section 4-10 of the

HMO Act contemplates (or could permissibly contemplate) a definition of "medical necessity" different than the definition contained in the plan, there is a question of more immediate concern. The critical question is whether Moran's state-law claim actually requires interpretation of the term "medical necessity." Plainly, it does not.

To be sure, if the plan's definition of medical necessity governs the independent reviewer's analysis, the independent reviewer would need to interpret the plan. But Rush's argument overlooks a vital intermediate step: the court's adjudication of Moran's claim. To adjudicate Moran's state-law claim, it is not necessary to interpret the term "medical necessity." Moran's complaint does not ask the court to make a determination about the medical necessity of the surgical procedure recommended by Moran's physician. Rather, Moran merely seeks compliance with the procedural requirements of Illinois' independent review statute. If her claim is successful and she obtains independent review, then the terms of her health plan may well be implicated in the independent review's analysis. But there is no need to interpret the terms of the plan to adjudicate Moran's request for independent review under the Illinois statute. ERISA does not completely preempt a state law claim unless the claim falls within the scope of ERISA section 502(a). Because of Moran's state-law claim can be resolved without interpreting a contract governed by federal law, her claim is not properly recharacterized as an ERISA claim. *Cf. Jass*, 88 F.3d at 1489.

In addressing Moran's state-law claim, a court may ultimately be convinced that independent physician review as contemplated by section 4-10 of the Illinois HMO Act conflicts with ERISA's civil enforcement scheme. But as previously explained, the possibility that ERISA may preempt a state-law cause of action does not mean the state-law

claim arises under federal law. *See Franchise Tax Bd.*, 463 U.S. at 25-27. "[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law" because the federal law serves only as a defense to the state law claims. *Rice*, 65 F.3d at 640. The Illinois courts are fully capable of analyzing section 4-10 of the HMO Act and deciding whether it is preempted by ERISA.

CONCLUSION

Moran's motion to remand is granted. This case is remanded to the Circuit Court of Cook County.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC.,) DANT.

No. 98 C 442

March 24, 1999

MEMORANDUM OPINION AND ORDER

SUZANNE B. CONLON, *Judge*.

Debra C. Moran ("Moran") filed a complaint for specific performance in the Circuit Court of Cook County against Rush Prudential HMO, Inc. ("Rush"). Moran suffers from brachial plexopathy and thoracic outlet syndrome. Rush denied coverage for a surgical procedure recommended by Moran's physician based on a plan exclusion for services "not medically necessary." Moran sought independent physician review of the medical necessity of the surgical procedure pursuant to section 4-10 of the Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* ("the HMO Act"). On January 26, 1998, Rush removed the case to federal court on the grounds that Moran's state law claim was completely preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* This court found Moran's claim not pre-

empted by ERISA because it did not seek to compel benefits and remanded the case to the Circuit Court of Cook County on June 2, 1998.

On November 2, 1998, the Circuit Court of Cook County granted Moran's request for an independent physician review under the HMO Act. The Circuit Court reserved ruling "on whether there is or is not preemption of that portion of the statute which requires coverage in the event the independent review determines the covered service to be medically necessary." Order of November 2, 1998, at ¶ 4. Following the independent review and recommended surgery, Moran asked the Circuit Court to order reimbursement for the medical expenditures. The Circuit Court requested that Moran amend her complaint to clarify the relief sought from Rush. On February 5, 1999, Moran filed an amended complaint seeking reimbursement from Rush in the amount of $94,841.27. Rush removed the action to this court again on February 12, 1999. Moran moves to remand this case to the Circuit Court of Cook County. Moran also moves for costs and expenses pursuant to 28 U.S.C. § 1447(c) for wrongful removal.

DISCUSSION

I. PROCEDURAL CRITERIA FOR REMOVAL

A defendant may file a notice of removal within 30 days of receiving a copy of the initial pleading setting forth the claim for relief upon which the action is based. 28 U.S.C. § 1446(b). The defendant files a "short and plain statement of the grounds for removal," attaching copies of the process, pleadings, and orders served upon him in the proceeding § 1446(a). If the suit initially plead is not removable, the defendant may file a removal notice "within thirty days after receipt by the defendant, through service or otherwise, of a copy of an amended pleading, motion, order or other paper

from which it may first be ascertained that the case is one which is or has become removable." § 1446(b). However, a case may not be removed on the basis of diversity of citizenship jurisdiction more than one year after the commencement of the action. *Id.*

Moran objects to Rush's removal procedure for two reasons. First, she contends Rush's second removal is improper in form because it does not contain all the relevant pleadings in the suit. Second, Moran asserts Rush waived its right to removal by going forward on the merits of her amended complaint in state court.

Regarding the content of Rush's removal notice, Rush has attached all pertinent papers. Together with its removal notice, Rush has submitted nineteen exhibits, including copies of Moran's amended complaint, previous state court orders, the independent physician's review, and subsequent correspondence between Rush and the independent physician. In sum, Rush has attached to its notice all information necessary in determining whether removal was proper.

Although removal procedures are strictly construed, failure to conform to the attachment rule is not a jurisdictional defect. Wright, Miller & Cooper, 14C Federal Practice and Procedure § 3733. Section 1446(a)'s directive requiring the attachments "is obviously intended to provide the district court with the record materials necessary to enable the court and the litigants to delineate the issues to be tried." *Riehl v. National Mutual Inc. Co.*, 374 F.2d 739, 742 (7th Cir. 1967). In light of § 1446(a)'s purpose, minor defects or omissions are "of no consequence." *Id.* (finding remand for failure to attach a copy of the complaint "would be to elevate form over substance"). Because Rush has included in its notice all papers relevant to the suit upon removal, it has satisfied § 1446(a)'s requirements.

Moran contends Rush waived its right to remove by going forward on the merits of her amended complaint in state court. In support of her argument, Moran cites two district court cases from other circuits finding that substantial activity on the merits of a case in state court constitutes a waiver of the right to remove. Moran would be advised to pay closer attention to the controlling law of this circuit, which holds that the waiver doctrine arise in repose to unclear timing requirements in the removal area and has no place in removal law after the 1948-49 revisions to § 1446(b). *Rothner v. City of Chicago*, 879 F.2d 1402, 1415 (7th Cir. 1989).

Rush has met the procedural requirements for removal. Rush filed its notice of removal with this court seven days after Moran filed the amended complaint that provided a basis for removal. Because Rush argues this court's jurisdiction is based on federal question jurisdiction, not diversity of citizenship, removal is permitted more than one year after the commencement of the action. Finally, Rush has provided the court with the papers needed to decide Moran's motion to remand.

II. SUBSTANTIVE CRITERIA FOR REMOVAL

Federal question jurisdiction exists for claims "arising under" the Constitution, laws, or treaties of the United States. 28 U.S.C. § 1331. A cause of action arises under federal law when the plaintiff's well-pleaded complaint raises issues of federal law. *Gully v. First National Bank*, 299 U.S. 109 (1936). Federal courts do not have original jurisdiction over a state law claim only because a defense to the claim raises a federal issue. This is true even if the plaintiff anticipates the defense and pleads it in his complaint. *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 14 (1983). Under the well-pleaded complaint rule, federal

preemption of a state claim is generally a defense; while preemption may extinguish the state claim, it does not convert an otherwise state law claim to one "arising under" federal law. *See id.* Thus, federal preemption does not normally authorize removal of a case from state to federal court. *Id.*

The Supreme Court has recognized a limited exception to the well-pleaded complaint rule in cases of complete preemption. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Lister v. Stark*, 890 F.2d 941, 943 (7th Cir. 1989). This term is really a misnomer "since the complete preemption doctrine is not a preemption doctrine but rather a federal jurisdiction doctrine." *Lister*, 890 F.2d at 944 n.1; *Bartholet v. Reishauer A.G.*, 953 F.2d 1073, 1075 (7th Cir. 1992). The complete preemption doctrine overrides the general rule that "the plaintiff is master of [her] pleadings." *Bartholet*, 953 F.2d at 1075. Even if a complaint purports to raise only state law claims, the state-law claims may be recharacterized as a federal claim so that removal is proper. *Taylor*, 481 U.S. at 64; Lister, 890 F.2d at 943. Recharacterization occurs when the preemptive force of a statute, as judged by congressional intent, is so strong as to displace entirely all state law causes of action in the particular area. *See Taylor*, 481 U.S. at 63-67. In other words, in certain situations "federal law so fills every nook and cranny that it is not possible to frame a complaint under state law." *Bartholet*, 953 F.2d at 1075.

Courts have been careful to distinguish complete preemption from the defense of preemption in the ERISA context. Section 514(a) provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This type of preemption has been termed conflict preemption. *Ingersoll-Rand v. McClendon*, 498 U.S. 133, 145 (1990). But the mere fact that ERISA preempts a state law cause of action does not mean

that the state claim arises under federal law. *See Franchise Tax Bd.*, 463 U.S. at 25-27. "[S]tate law claims that are merely subject to conflict preemption under § 514(a) are not recharacterized as claims arising under federal law" because the federal law serves only as a defense to the state law claims. *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995).

ERISA does not completely preempt a state law claim unless the claim falls within the scope of ERISA's civil enforcement provision, § 502(a). 29 U.S.C. § 1132; *Taylor*, 481 U.S. at 64-66. In particular, § 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption permits removal "when the plaintiff's own claim depends on ERISA, and the effort to craft a claim under state law reflects artful pleading." *Blackburn v. Sundstrand Corp.*, 115 F.3d 493, 495 (7th Cir. 1997). "If a state law claim has been 'displaced' and therefore completely preempted by § 502(a), then a plaintiff's state law claim is properly 'recharacterized' as one arising under federal law." *Rice*, 65 F.3d at 640 (citations omitted).

Although the defense of conflict preemption does not confer subject matter jurisdiction, there is a noted interrelationship between a finding of complete preemption under § 502(a) and conflict preemption under § 514(a). *Rice*, 65 F.3d at 646 n.10. "Where a claim is completely preempted under § 502(a) it is necessarily preempted under § 514(a)." *Id.* But the converse does not hold true, for not every state claim related to ERISA under § 514(a) is completely preempted.

The Seventh Circuit recently identified three factors pertinent to the question of complete preemption under § 502(a). These factors are: "(1) whether the 'plaintiff [is] eligible to bring a claim under that section;' (2) whether the plaintiff's 'cause of action falls within the scope of an ERISA provision that the plaintiff can enforce via § 502(a);' and (3) whether the plaintiff's 'state law claim cannot be resolved without an interpretation of a contract governed by federal law." *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). When all three factors are present, a state-law claim is properly recharacterized as an ERISA section 502(a) claim. *Id.* at 1489.

Although in its remand order of June 2, 1998, this court found Moran's claim requesting an independent review did not meet the three *Jass* factors and thus was not preempted by ERISA, the court acknowledged the difference between Moran's then claim for specific performance and a potential future claim to compel benefits: "If her claim is successful and she obtains independent review, then the terms of her health plan may well be implicated in the independent reviewer's analysis." Memorandum Opinion and Order of June 2, 1998, at 7. Indeed, Moran has now altered her claim to compel plan benefits in the form of reimbursement for the surgical procedure recommended by the independent reviewer. Her current claim for reimbursement demands an interpretation of the benefits provided for "medical necessities" under her Rush HMO plan. In other words, her claim requires interpretation of a contract governed by federal law, satisfying the third *Jass* criterion. The first and second criteria are also met by Moran's claim to compel benefits. Regardless of how she characterizes it, Moran's current claim is a § 502(a) denial of benefits claim. *Jass*, 88 F.3d at 1489. Moran asserts her right to have Rush cover the costs of medical treatment pursued outside of her HMO plan.

Rush refused to reimburse her for the treatment. Rush's refusal is a determination of benefits within the meaning of ERISA. *Id.* Accordingly, Moran's claim for reimbursement is preempted by ERISA. *Id. See also Corporate Health Ins. Inc. v. Texas Dept. of Ins.*, 12 F. Supp. 2d 597, 625 (S.D. Tex. 1998) (finding Texas statute providing for independent review for adverse benefit determinations was preempted by ERISA).

Even if a claim meets the three *Jass* criteria for preemption, it may nonetheless fall under an ERISA "savings clause" and avoid preemption. 29 U.S.C. § 1144(b)(2)(A). State statutes that regulate the insurance industry are subject to the savings clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). A statute regulating insurance must meet the following three criteria in order to avoid preemption: 1) the statute has the effect of transferring or spreading a policyholder's risk; 2) the statute is an integral part of the policy relationship between the insurer and insured; and 3) the statute is limited to entities within the insurance industry. *Id.* at 742-43. If a statute fails to satisfy any of the three criteria, the ERISA savings clause does not apply. *CIGNA Healthplan of La. v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996).

Illinois' HMO Act does not operate to transfer or spread a policyholder's risk. The HMO Act only applies in individual circumstances when a plan administrator has denied benefits coverage for procedures not recognized as "medical necessities." The HMO Act thus affects the administration and adjudication structure of a health plan in particular instances. It does not affect the disbursement of benefits at large to all policyholders, nor does it mandate or deny a certain class of benefits. *See Metropolitan Life*, 471 U.S. at 744. Accordingly, the HMO Act is not subject to ERISA's savings

clause. Because Moran's claim for reimbursement arises under federal law, removal is proper.

CONCLUSION

Moran's motion to remand and for costs pursuant to 28 U.S.C. § 1447(c) is denied.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT.

No. 98 C 442

May, 6, 1999

ORDER

SUZANNE B. CONLON, *Judge*.

Debra Moran ("Moran") sues Rush Prudential HMO, Inc. ("Rush") to compel health plan benefits pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq*. Rush removed the action to this court for the second time on February 12, 1999. On March 22, 1999, the court denied Moran's motion to remand the suit to the Circuit Court of Cook County. Moran moves for reconsideration.

Motions for reconsideration serve a limited purpose. On reconsideration, a party may not introduce new evidence or legal theories that could have been presented earlier. *Caisse Nationale de Credit Agricole v. CBI Industries, Inc.*, 90 F.3d 1264, 1269 (7th Cir. 1996). Nevertheless, a motion to reconsider may be proper to correct manifest errors of law or

to present newly discovered evidence. *In the Matter of Prince*, 85 F.3d 314, 324 (7th Cir. 1996), *cert. denied*, 117 S. Ct. 608 (1996). Ultimately, a district court may grant a motion to reconsider so long as the court does not abuse its discretion. *Id*.

According to Moran, the Supreme Court's recent decision in *Unum Life Ins. Co. v. Ward*, 97-1868, 1999 U.S. Lexis 2839 (April 20, 1999), affects this court's March 22 ruling. In denying Moran's motion for remand, this court concluded that because the Illinois independent review law, 215 ILCS § 125/4-10 ("Illinois HMO Act"), was not a state law regulating insurance, it was preempted by ERISA and not subject to ERISA's "savings clause." This decision relied on *CIGNA Healthplan of Louisiana v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996), which interpreted existing Supreme Court law to require satisfaction of all three McCarran-Ferguson factors before ERISA's savings clause would apply. In *Unum*, however, the Supreme Court clarified its position on the McCarran-Ferguson factors, holding that those factors are considerations to be weighed; none is dispositive by itself. 1999 U.S. Lexis 2839, at *27. Moran argues that upon weighing all the factors, the Illinois HMO Act falls within ERISA's savings clause.

The court need not analyze the three McCarran-Ferguson factors because the Illinois HMO Act is exempt from the savings clause. ERISA preemption analysis is divided into three stages. First, the court determines whether the state law in question is preempted by ERISA as related to an employee benefit plan. 29 U.S.C. § 1144(a); *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 650 (7th Cir. 1995). If the state law is preempted, the court decides whether the savings clause "returns to the States the power to enforce those state laws that 'regulat[e] insurance.'" *Maciosek v. Blue Cross & Blue Shield of Wisconsin*, 930 F.2d 536, 539 (7th Cir. 1991); 29

U.S.C. § 1144(b)(2)(A). Even if the McCarran-Ferguson factors are satisfied, the state law might fall within the "deemer clause" exception to the savings clause, removing the statute once again from state enforcement as preempted by ERISA. 29 U.S.C. § 1144(b)(2)(B); *Winstead v. Indiana Ins. Co.*, 855 F.2d 430, 434 at n.4 (7th Cir. 1988).

In its March 22 order, this court did not reach the third part of the ERISA analysis because it determined the Illinois HMO Act was not subject to the savings clause for failure to meet all three McCarran-Ferguson factors. The court now declines to analyze the three factors because the deemer clause exempts the Illinois HMO Act from the savings clause. The deemer clause relieves employee benefit plans from state laws regulating insurance by removing the plans from the savings clause's ambit as defined in 29 U.S.C. § 1144(b)(2)(A). *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Although the insurance company that insures the benefit plans remains subject to the savings clause and state law regulation, the ERISA plan is bound by state insurance regulations only "insofar as they apply to the plan's insurer." *Id.* The ERISA plan itself is preempted and exempt from the savings clause. *Id.* Because the Illinois HMO Act has the effect of directly regulating employee benefit plans rather than an insurance company, it is exempt from the savings clause under the deemer clause. 29 U.S.C. §§ 1144(b)(2)(A), (B). Thus, ERISA has preempted the Illinois HMO Act, making removal proper.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

DEBRA C. MORAN, PLAINTIFF,

v.

RUSH PRUDENTIAL HMO, INC., DEFENDANT.

No. 98 C 442

June 15, 1999

MEMORANDUM OPINION AND ORDER

SUZANNE B. CONLON, *Judge*.

Debra Moran ("Moran") sues Rush Prudential HMO, Inc. ("Rush") to compel health plan benefits pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* (Counts II and III). Rush also asserts a claim under § 125/4-10 of the Illinois Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* ("HMO Act") (Count I). Rush moves for summary judgment pursuant to Fed. R. Civ. P. 56.

BACKGROUND

All facts are uncontested unless otherwise stated. At all relevant times, Rush was Moran's health care insurer; Moran was covered through her spouse's plan governed by ERISA. Def. 12M ¶ 1. Prior to October 1997, Moran was diagnosed

with thoracic outlet syndrome, a nerve compression syndrome. *Id.* ¶ 5. Although most nerve compression syndromes are mild and effectively treatable with conservative physiotherapy, more severe sensory or motor deficits may ultimately require surgical management. *Id.* ¶ 6.[1] Surgery is not usually indicted unless conservative measures to manage the syndrome through physiotherapy fail. *Id.* ¶ 7. If surgery becomes necessary, the standard procedure involved decompression by way of first rib resection (complete removal of the uppermost rib) or first rib resection with scalenectomy (removal of the rib and the attached muscle). *Id.* If necessary, three to five power loupe magnification, during which the surgeon wears a goggle-like apparatus that magnifies the immediate view, may be used to conduct a neurolysis (removal of scar tissue surrounding the injured nerve). *Id.*

During the course of treatment, Moran obtained the name of Dr. Julia Terzis ("Dr. Terzis"), a Virginia surgeon not associated with Rush, who performs complicated surgery that consists of rib resection, extensive scalenectomy, and microneurolysis of the lower roots of the brachial plexus under intraoperative microscopic magnification. *Id.* On October 14, 1997, Dr. Arthur LaMarre, ("Dr. LaMarre"), Moran's primary care physician, petitioned Rush for approval of Dr. Terzis' microneurolysis surgery. *Id.* ¶ 13. On October 23, 1997, Rush denied approval, a decision that Moran appealed.

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[1] Moran has moved to strike Dr. Rosenberg's affidavit, which serves as the source of this 12M statement. Moran asserts Dr. Rosenberg's affidavits does not meet Fed. R. Civ. P. 56(e) requirements because it is not based on personal knowledge. However, Dr. Rosenberg's affidavit is in fact founded on his personal knowledge as the medical director for Rush's health plans and the person who reviewed Moran's claim for payment submitted to Rush after her surgery. Therefore, his affidavit satisfied Rule 56(e), and Moran's motion to strike his affidavit is denied.

Id. ¶ 14. In response to her appeal, Rush requested the expert opinions of two board certified thoracic surgeons, Dr. Raymond A. Dieter ("Dr. Dieter") and Dr. William H. Warren ("Dr. Warren"), with whom Moran had previously consulted regarding her nerve compression syndrome. *Id.* ¶ 15. Rush affirmed its denial of coverage for Dr. Terzis' microneurolysis surgery, concluding the procedure was not medically necessary. *Id.* ¶¶ 23, 24. At the same time, Rush informed Moran it would cover the standard thoracic outlet syndrome surgery of first rib resection with scalenectomy. *Id.*

Moran chose to undergo Dr. Terzis' microneurolysis surgery; thereafter Rush received a benefits claim for the costs of the surgery. *Id.* ¶ 25. While investigating Moran's benefits claim, Rush obtained the opinions of two additional experts, Dr Gerald Harris ("Dr. Harris") and Dr. John C. Alexander, Jr. ("Dr. Alexander"). *Id.* ¶ 26. Rush provided all physicians consulted with information concerning Dr. Terzis' microneurolysis surgery and Moran's medical records. *Id.* Because Drs. Harris and Alexander admitted to a certain lack of expertise in the area, Rush consulted with Dr. Susan E. MacKinnon ("Dr. MacKinnon"), the Chief of Plastic and Reconstructive Surgery at Washington University School of Medicine in St. Louis, and Dr. A. Lee Dellon ("Dr. Dellon"), an expert in plastic and reconstructive surgery at Johns Hopkins Medical Center. *Id.* ¶ 28. After reviewing the reports of all experts, Dr. Alan B. Rosenberg ("Dr. Rosenberg"), Rush's medical director, concluded Dr. Terzis' surgery had not been medically necessary and denied Moran's benefits claim on January 18, 1999. *Id.* ¶ 37.

DISCUSSION

I. SUMMARY JUDGMENT STANDARD

A movant is entitled to summary judgment under Rule 56 when the moving papers and affidavits show there is no

genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Unterreiner v. Volkswagen of America, Inc.*, 8 F .3d 1206, 1209 (7th Cir. 1993). Once a moving party has met its burden, the non-moving party must go beyond the pleadings and set forth specific facts showing there is a genuine issue for trial. Fed. R. Civ. P. 56(e); *Becker v. Tenenbaum-Hill Assoc., Inc.*, 914 F.2d 107, 110 (7th Cir. 1990). The court considers the record as a whole and draws all reasonable inferences in the light most favorable to the party opposing the motion. *Fisher v. Transco Services-Milwaukee, Inc.*, 979 F.2d 1239, 1242 (7th Cir. 1992). A genuine issue of material fact exists when "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Stewart v. McGinnis*, 5 F.3d 1031, 1033 (7th Cir. 1993).

II. NATURE OF MORAN'S CLAIMS

Moran's summary judgment response first addresses this court's lack of jurisdiction over her claims because they are state law claims not preempted by ERISA. After finding Moran's artful pleading in her first amended complaint constituted nothing more than a claim to compel benefits under ERISA § 502(a) and denying Moran's motion to remand the suit to state court, this court permitted her to file a second amended complaint. *See* Memorandum Opinion and Order of March 22, 1999; Order of April 22, 1999. Although the federal rules demand liberality in granting leave to amend complaints, plaintiffs abuse Fed. R. Civ. P. 15(a) when they merely reframe previously deficient claims in a new complaint. *Foman v. Davis*, 371 U.S. 178 (1962); *Rodgers v. Lincoln Towing Service, Inc.*, 771 F.2d 194 (7th Cir. 1985). Moran's second amended complaint is on the edge of abuse. Generous amendment policy ensures that inarticulate or

misguided plaintiffs with meritorious claims are not forced out of court on a technicality; it does not exist to provide plaintiffs a new forum for relitigating previously rejected arguments in thinly veiled disguise.

Although a plaintiff is master of her claim and may theoretically choose whether to plead under state or federal law, she is limited in her choice of law by the remedy she seeks. *Federated Department Stores, Inc. v. Moitie*, 452 U.S. 394, 397, n.2 (1981). If a plaintiff's desired remedy is controlled entirely by federal law, she cannot properly assert a state law cause of action. If a federal right of action has replaced a state right of action, thus preempting state law, a plaintiff necessarily is stating a federal claim whether or not she wishes to do so and regardless of the language in which the claim is couched. *Avco Corp. v. Aero Lodge No. 735*, 390 U.S. 557 (1968).

Under ERISA, a state law claim is completely preempted and recharacterized by federal law when the claim falls within the scope of ERISA's civil enforcement provision, § 502(a). 29 U.S.C. § 1132; *Met. Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). In particular, section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption occurs when the plaintiff's own claim depends on ERISA, regardless of any artful pleading efforts to craft a claim under state law. *Blackburn v. Sundstrand Corp.*, 115 F 3d 493, 495 (7th Cir. 1997). "If a state law claim has been 'displaced' and therefore completely preempted by § 502(a), then a plaintiff's state law claim is properly 'recharacterized' as one arising under federal law." *Rice v. Panchal*, 65 F.3d 637, 640 (7th Cir. 1995) (citations omitted).

The procedural history of this case is instructive in determining the precise nature of Moran's current claims. On January 23, 1998, Moran filed a complaint for specific performance against Rush in the Circuit Court of Cook County, seeking to enforce § 4-10 of the HMO Act. Section 4-10 makes two distinct provisions. First, it requires all health maintenance organizations ("HMOs") to provide independent review in the event of a dispute between die HMO and a primary care physician regarding a proposed patient service. 215 ILCS § 125/4-10. Second, § 4-10 requires the HMO to financially cover the service if the independent review concludes the proposed service is medically necessary. *Id.*

Rush removed the suit to this court claiming ERISA preempted § 4-10 in its entirety. This court remanded the case to state court after finding that Moran's claim for specific performance implicated only § 4-10's first provision, which was not preempted by ERISA. *See* Memorandum Opinion and Order of June 2, 1998. In her first complaint, Moran had not asked the court to interpret the term "medical necessity," a task that could implicate the terms of her health plan and thus subject her claim to preemption. *See id.* at 7. Instead, she merely sought compliance with the Illinois statute's procedural requirements of providing an independent physician reviewer. *See id.*

On November 2, 1998, the state court granted Moran's request for an independent physician review under the HMO Act. The court reserved ruling on whether there is or is not preemption of that portion of the statute which requires coverage in the event the independent review determines the covered service to be medically necessary. *See* Def. Resp. Second Mot. Remand, Ex. C. Following the independent review and recommended surgery, Moran asked the state court to order her reimbursement for the medical expenditures. The state court requested that Moran amend her complaint to

clarify the relief sought from Rush. On February 5, 1999, Moran filed an amended complaint seeking reimbursement for the surgery from Rush in the amount of $94,841.27.

Rush again removed the action to this court on February 12, 1999, asserting that Moran's remaining cause of action constituted a claim for denial of benefits under her health policy plan. On March 22, 1999, this court denied Moran's motion to remand, finding her claim for reimbursement preempted by ERISA's civil enforcement policy in § 502(a). Section 502(a)(1)(B) permits a participant or beneficiary of an ERISA plan to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Complete preemption under § 502(a) occurs when three factors are present: (1) the plaintiff is eligible to bring a claim under that section; (2) the plaintiff's state law cause of action falls within the scope of an ERISA provision that can be enforced via § 502(a); and (3) the plaintiff's state law claim cannot be resolved without an interpretation of a contract governed by federal law. *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1487 (7th Cir. 1996). Whereas Moran's claim for specific performance of the independent review itself did not require interpretation of a contract governed by federal law, her claim for reimbursement requires an examination of the benefits owed under her health policy plan. Specifically, § 4-10's "medically necessary" standard must be examined according to the health plan's own standard for coverage in order to determine whether reimbursement is owing. Enforcing the second part of the statute without question or reference to Rush's policy under which Moran is insured would interfere with ERISA's statutory enforcement scheme and would allow a patient to circumvent

the health care plan's denial of benefits by compelling an independent review under the state statute.

After her second motion to remand was denied, Moran amended her complaint a second time, again attempting to state a claim for reimbursement under § 4-10. Her continual references to the Illinois HMO Act notwithstanding, Moran's claims still constitute nothing more than an action to compel health plan benefits. In her three count complaint alleging violation of the Illinois HMO Act and breaches of contract and fiduciary duty under ERISA, Moran frames Rush's alleged harm in terms of its failure timely to provide the independent review and pay for the surgery. By focusing on Rush's alleged failure to provide a timely independent review, Moran attempts to construe the remedy sought as one conferred by the first part of § 4-10, which is not preempted. However, the actual damages she alleges are expenses she was forced to pay for her surgery because Rush did not pay for the procedure. She does not allege she would not have had the surgery had she known Rush would refuse to pay for it. Nor does she allege any other damages stemming from the independent review itself. Her damage allegations simply amount to a claim of harm by Rush's refusal to reimburse her for the surgery. Therefore, Moran's allegations remain a claim to compel benefits under § 502(a). Because the remedy sought arises under federal law, this court has subject matter jurisdiction over Moran's suit.

III. RUSH'S BENEFITS CLAIM DETERMINATION

A. Standard of Review

In refusing to reimburse Moran the cost of her surgery, Rush reviewed the independent physician's conclusions in accordance with its internal guidelines for service coverage. Rush's benefits claim determination is subject to a highly deferential standard; the court may reverse Rush's decision

only if Moran shows the determination was made arbitrarily and capriciously. *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144 (7th Cir. 1998). When an ERISA regulated benefit plan grants the administrator or fiduciary discretionary authority to determine benefits eligibility or to construe the terms of the plan, the denial of benefits will be overturned only if the administrator's decision constitutes an abuse of discretion. *Id.* at 1147. "[I]f the decision made by the administrator 'was made rationally and in good faith,' [a court] will not second-guess whether the decision is right." *Id.* (citing *Brown v. Retirement Committee of Briggs & Stratton*, 797 F.2d 5:21, 529 (7th Cir. 1986) (citations omitted)).

The court must uphold a claim decision if the claim administrator "makes an informed judgment that articulates an explanation that is satisfactory in light of the relevant facts, *i.e.* one that makes a 'rational connection' between the issue to be decided, the evidence in the case, the text under consideration, and the conclusion reached." *Exbom v. Central States Southeast and Southwest Areas Health and Welfare Fund*, 900 F.2d 1138, 1143 (7th Cir. 1990) (citations omitted)).

In evaluating whether a claim determination was arbitrary or in other words "downright unreasonable," the court must focus on the information and evidence available before the claim administrator at the time of its determination. *Donato v. Met. Life. Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994). Even where a claim administrator has equally plausible but conflicting facts as to whether a particular claim is entitled to coverage, it is not arbitrary and capricious for the claim administrator to conclude the claim is not covered. *See, e.g., Smith v. Office of Civilian Health and Medical Program of the Uniformed Services*, 97 F.3d 950, 956-57 (7th Cir. 1996).

B. Medical Necessity of Moran's Microneurolysis Surgery

The evidence shows Rush did not abuse its discretion or act arbitrarily in denying Moran's benefits claim. In reaching its determination, Rush acted in accordance with the protocol set out in Moran's insurance certificate. Specifically, Moran's certificate afforded Rush "the broadest possible discretion to interpret the terms of the Group Contract and the Certificate and to determine which benefits the Employee and his/her eligible dependents are entitled to receive." Def. Ex. 1 at 7. The certificate also stated the method Rush would use to evaluate the medical necessity of services and coverage. The evaluation method includes an examination of prevailing opinions within the appropriate medical specialty and published reports in authoritative medical literature. *Id.* at 21. To this end, Rush solicited expert opinions of leading physicians in the thoracic outlet syndrome area and requested pertinent literature from Dr. Terzis, the physician who performed Moran's surgery.

All the physicians whom Rush consulted would not have performed the precise procedure executed by Dr. Terzis. After reviewing medical literature and Moran's medical records, the experts consulted concurred that the prevailing technique for treating Moran's case would be a first rib resection with scalenectomy. *See* Def. Exs. 3, 9, 14, 15, 19, 20. Only Dr. Dellon stated he would have done the same type of surgery performed by Dr. Terzis. Def. Ex. 20 at 2. However, when Dr. Dellon further described the surgery he would have performed, his procedure differed significantly from Dr. Terzis' surgery. Whereas Dr. Terzis employed an operating microscope in order to perform an extensive exploration of the right supraclavicular plexus and a microneurolysis of the lower roots of Moran's right brachial plexus, Dr. Dellon uses loupe magnification to perform a less

intrusive and lengthy surgery. Dr. Dellon allowed that the length of surgery can vary based "upon the problems encountered, the surgeon's ability and the degree of care taken." *Id.* But the main difference between Dr. Terzis' fourteen hour operation and Dr. Dellon's two or three hour procedure appears to lie in the extent of peripheral nerve exploration. Prior to surgery, Dr. Terzis informed Moran's primary care physician she wished to perform an extensive exploration to identify all brachial plexus roots. Def. Ex. 4. In contrast, Dr. Dellon concentrates on a smaller area where extensive scar formation is likely. Def. Ex. 20. Dr. Rosenberg considered these differences in making his benefits determination. *See* Rosenberg Aff. ¶ 34.

Dr. MacKinnon, a thoracic outlet syndrome expert who coauthored a book with Dr. Dellon and was recommended to Rush by Dr. Terzis herself, opined based on her extensive experience and literature review that a detailed internal neurolysis creates no benefits over the more standard first rib resection and scalenectomy procedure Rush recommended for Moran. Def. Ex. 19. In fact, Dr. MacKinnon noted a greater danger associated with Dr. Terzis' procedure: "Because a detailed internal neurolysis involves operating directly on the nerve and even at times within the nerve, it can be associate with some damage to the nerve which can be associated with pain." *Id.* Moreover, "[i]f such extensive neurolysis lengthens the time of the operative procedure, then this prolonged general anesthetic exposure can be associated with its own separate risks to the patient." *Id.*

Moran argues the expert opinions Rush solicited are inapposite because they address proper thoracic outlet syndrome surgery, whereas Dr. Terzis treated her for both thoracic outlet syndrome and brachial plexopathy. Moran completely misses the mark in this argument. The entire point of the expert opinions rendered is that Moran's condition did not

require extensive brachial plexopathy treatment. *See, e.g., id.* ("Certainly there does not seem to be any reason to neurolyse the upper part of the plexus").

Moran's final argument concerns Rush's procedure for reviewing her benefits claim. She takes exception with the facts that Dr. Rosenberg's "post-hoc 'elective' decision to re-review Moran's request for coverage" occurred almost a year after her surgery and that "[t]he other physicians who reviewed the surgical outcome did so ex parte, without Ms. Moran's approval or knowledge." Pl. Resp. at 12-13. However, it was Moran's own decision to ignore Rush's previous denial of coverage for Dr. Terzis' proposed surgery and pay for the surgery herself that prompted her renewed benefits claim, which in turn necessitated Dr. Rosenberg's review. Moreover, once Moran renewed her benefits claim and placed the performed surgery at issue, she implicitly gave Rush the authority to review the surgery itself and seek opinions on it. Moran could hardly prefer that Rush seek expert opinions on the surgery's medical necessity with no reference to her particular case. Indeed, the determination of whether a procedure is medically necessary is case specific. In accordance with the policy stated in Moran's health insurance certificate, Rush had full authority to consult with other physicians regarding Moran's treatment and medical history.

CONCLUSION

Moran has not submitted evidence establishing Rush's denial of coverage for Dr. Terzis' surgery was arbitrary and capricious. Accordingly, the motion for summary judgment is granted.